

THE COMMISSION ON MENTAL HYGIENE REFORM

FINAL REPORT

DECEMBER 15, 1999

TABLE OF CONTENTS

Foreword.....	i
The Members of the Commission.....	ii
Acknowledgments.....	iv
Chapter One: The Need for Reform.....	1
Chapter Two: Involuntary Commitment Today in West Virginia.....	5
Chapter Three: Discovering the Issues.....	8
Chapter Four: The Reform Proposal.....	14
Chapter Five: The Implementation Proposal.....	18
Chapter Six: Reports and Recommendations	20
I. Standards and Procedures.....	23
II. Services.....	39
III. Accountability, Oversight, and Education.....	51
Appendices	
Appendix A: Administrative Order	A-1
Appendix B: Public Forum Summary By City	B-1
Appendix C: Comments from the Public Forums and Written Submissions.....	C-1
Appendix D: Survey Instruments	D-1
Appendix E: Resource List	E-1

Appendix F: Proposed Implementation Time Line.....F-1

FORWARD

When we, the Commission on Mental Hygiene Reform, began this endeavor, I called upon the members of the Commission to reach into their pasts -- indeed, into their souls -- for the reasons they became part of the helping professions -- idealism and a desire to help other people. I asked the Commission's members to set aside "turf" and the "what's in it for me" attitude which so often torpedoes reform efforts. I asked them to help make the "mental hygiene system" a far more humane and effective response to the pain and humiliation that often accompanies a mental illness crisis. I can report that the Commission has risen to that challenge. I am very thankful and proud to present this Final Report as proof of that accomplishment.

The Commission has produced a set of recommendations for reform in the areas of legal standards and procedures, improved services, and a system of accountability and regular reexamination of the entire system, that constitute a giant leap forward. Producing this body of work took honest and open discussion, compromise, and a belief that West Virginia's current mental hygiene system must change, to more effectively and responsively address the needs of persons with mental illness.

The Commission reached a consensus on all of the recommendations found in this Final Report. Some of these recommendations are directed to the West Virginia Legislature, others go to the Supreme Court of Appeals and still others to the Department of Health and Human Resources.

We ask the State's Legislators, the Justices of the Supreme Court, the Secretary of the Department of Health and Human Resources, and all of the other entities to whom recommendations are directed to remember their commitment to all of the people of this great State including those tens of thousands of West Virginians with serious mental illnesses. We ask that they carefully consider each of the recommendations contained within this report. Finally, and most important, we ask that they remember their idealism and the zeal for positive change that brought them to public office. We ask that they use that zeal to help bring about desperately needed reform in West Virginia's system of involuntary commitment.



THE COMMISSION ON MENTAL HYGIENE REFORM

William F. Byrne, Esq., Chair
Byrne & Hedges

**Marcia Ashdown, Esq.,
Subcommittee Chair**
Prosecutor
Monongalia County

Dallas Bailey, Ph.D.
Governor's Cabinet on Children & Families

Mildred Bateman, M.D.
Clinical Director
Mildred Mitchell Bateman Hospital

Larry Belcher
Chief Executive Officer
W. Va. Mental Hygiene Consumers' Ass'n
Director, CONTAC

Jonathan Boggs
Commissioner
Behavioral Health and Health Facilities
Department of Health & Human Resources

Kent Bryson, Esq.
West Virginia Advocates

Betsy Castle
Circuit Clerk
Preston County

Jack C. Clohan, Jr.
Administrator
William R. Sharpe, Jr. Hospital

Richard L. Coffinbarger
Crisis Services Specialist
Office of Behavioral Health Services
Department of Health & Human Resources

Honorable Mary Pearl Compton
Chair
Health and Human Resources Committee
West Virginia House of Delegates

Wayne Dickison
Certified Substance Abuse Counselor

Fred Donovan, Psy.D.
Director
East Ridge Health Systems

Tara Harper
Associate Director for Computer Support
Supreme Court of Appeals of West Virginia

Sue Salmons Hage
Director of Community Organization
Office of Social Services
Department of Health & Human Resources

Ted J. Johnson
Director, Division of Mental Health &
Community Rehabilitation Services
Department of Health & Human Resources

John Justice, M.D.
Director, Division of Forensic Psychiatry
Chestnut Ridge

Elizabeth McCullough

State President
National Alliance for the Mentally Ill - WV

Richard Kiley, Ph.D.
Executive Director
Appalachian Community Health Center

Honorable Lawrance Miller
Chief Judge
Preston County Circuit Court

Jane Moran, Esq.
Jane Moran Law Offices

Henry W. "Bucky" Morrow, Jr., Esq.,
Subcommittee Chair
Former Mental Hygiene Commissioner

Mike Mowery, Esq.
Chief Counsel
House Judiciary Committee

Catherine Munster, Esq.
McNeer, Highland, McMunn & Varner

Vito Mussomeli, Esq.
Public Defender Corporation

Joan E. Ohl
Secretary
Department of Health & Human Resources

Honorable Worthy Paul
Magistrate
Ohio County Magistrate Court

Robert J. Rush, Ph.D.
Psychologist
Behavioral Science Associates, Inc.

William Senseney

Sheriff
Jefferson County

James M. Stevenson, M.D.
Subcommittee Chair
Behavioral Medicine and Psychiatry Dept.
West Virginia University

Ward D. Stone, Jr., Esq.
Former Mental Hygiene Commissioner
Spilman, Thomas & Battle

David Sudbeck
Hartley Court Monitor

Steven J. Summer
President/CEO
West Virginia Hospital Association

Honorable Martha Yeager Walker
Chair
Health and Human Resources Committee
West Virginia Senate

Robert D. Williams
Executive Director
United Summit Center

Honorable William R. Wooton
Judiciary Chair
West Virginia Senate

Adolphus Young, Jr.
Branch Office Manager
WV Division of Rehabilitation Services

Loretta Young
Office of Development
Concord State College

ACKNOWLEDGMENTS

The Commission would like to thank the many people without whose participation this report would not have been possible.

First and foremost, we extend our gratitude to the **citizens** (the consumers of mental health services, their family members, court personnel, service providers, law enforcement officers, and the many others) who attended and spoke at the public hearings, responded to surveys, or wrote comments about their experiences with involuntary commitment proceedings. Many of these people shared deeply personal, sometimes heart-wrenching stories of their experiences with the present involuntary commitment system. It is to them we dedicate this report.

We are also indebted to **Chief Justice Larry V. Starcher** of the Supreme Court of Appeals of West Virginia, whose unwavering belief in the need for effective and humane reform led to the creation of the Commission.

We especially want to acknowledge the chairs of the Commission's three subcommittees and the staff attorneys who assisted them. The Commission spent countless hours in the subcommittee process, reviewing data, grappling with complex issues, and considering the impact of the recommendations that appear in this report. The subcommittees' in-depth analyses, and resulting expertise, allowed the Commission to finish this significant body of work in well under one year.

Marcia Ashdown	Chair, Subcommittee One: Standards and Procedures
Peter Chambers	Staff Attorney
Gail Michelson	Staff Attorney
James M. Stevenson, M.D.	Chair, Subcommittee Two: Services
Vince Trivelli	Staff Attorney
H. W. "Bucky" Morrow, Jr.	Chair, Subcommittee Three: Accountability and Oversight
Tom Rodd	Staff Attorney

Last, but not least, we thank the staff of the **Administrative Office of the Courts** for their diligent and able assistance.

Leah H. Byrne	Summer Intern
Alison McBurney Chambers	Commission Counsel
Melissa Crawford	Deputy Director, Court Services Division
Debbie Farmer	Court Services Analyst, Court Services Division
Molly Hatcher	Summer Intern
Bettina Jordan	Summer Intern
Jenifer Lee	Administrative Assistant

CHAPTER ONE: THE NEED FOR REFORM

West Virginia's "mental hygiene" laws govern the involuntary hospitalization of persons with mental illness, addiction, and retardation. Most of West Virginia's current mental hygiene laws were enacted more than twenty-five years ago.

At that time, prolonged institutionalization in a psychiatric hospital was still a customary treatment for severely disabling and chronic mental illnesses like schizophrenia, bipolar and obsessive-compulsive disorders, and depression. Average stays in state psychiatric hospitals for persons with these disorders were **more than fifteen years**. (Currently, average psychiatric hospitalization stays are closer to **fifteen days**.) Similarly, lengthy institutionalization was common for chronic addicts (alcohol and other) and persons with varying levels of mental retardation.

To protect the constitutional and human rights of people who have brain-related disorders, particularly when long-term institutionalization was an issue, the Legislature vested the State's judicial system with the task of determining whether, when, and how a person should be involuntarily hospitalized or treated because of mental disorders. Procedures and standards were designed to assure that due process is guaranteed in all commitment proceedings, and that the least restrictive form of treatment is utilized.

These principles are still fundamental. However, since the enactment of West Virginia's involuntary commitment laws, there has been a dramatic increase in knowledge about mental disorders, and a concurrent dramatic change and evolution -- indeed, a revolution -- in our society's response to and treatment of these mentally disabling conditions.

Continued research, improved testing and diagnostic tools, and more effective medications have led to new therapeutic approaches and that were never before imagined. For example, psychiatric hospitalization is now seen as only one

(costly but sometimes essential) of many choices on an evolving menu of treatment options. Crisis intervention centers, community workers, and other nontraditional community treatment programs are often a cost-effective, less restrictive alternative to traditional inpatient hospitalization. Recurrent hospitalizations, commonly due to failure to take medication, can be substantially reduced or avoided by follow-up support and treatment in a community setting.

Despite these substantial and ongoing changes in society's understanding of, and response to, mental disorders and conditions, there has been little corresponding change in the involuntary hospitalization and treatment laws. Although all participants have the best of intentions, West Virginia's mental hygiene system -- on both a procedural and substantive level -- has not kept up with the times.

Because of these concerns, it is widely believed -- by consumers of mental health services, their family members and friends, judicial officers, prosecutors, advocates, law enforcement officials, physicians, social workers, and other concerned and affected persons -- that West Virginia's mental hygiene system should be improved.

In both 1991 and 1996, legislative efforts to update West Virginia's involuntary commitment laws were unsuccessful, primarily because a substantial consensus behind the recommended changes had not been developed prior to their consideration by the Legislature.

In its December 1998 "Final Report," the Commission on the Future of the West Virginia Judiciary -- after reviewing the involuntary commitment system as part of an overall look at issues facing West Virginia's judicial system -- recommended that a "mental hygiene commission" be created. The Commission on the Future recommended the appointment of:

[A] “Mental Hygiene Commission” to review the current mental hygiene system. The Commission should be made up of members of the legislature, governor’s office, judicial system, advocates, defense counsel, prosecutors, family members and other appropriate individuals.¹

In response, the Supreme Court of Appeals of West Virginia appointed the Commission on Mental Hygiene Reform in February 1999 to conduct a comprehensive review of the State’s mental hygiene system. Please see Appendix A for the Administrative Order establishing the Commission.

Underlying the Commission’s creation is the Supreme Court’s commitment to two fundamental principles: (1) recognizing and protecting the rights of all persons with mental illness; and (2) ensuring that West Virginia’s laws are congruent with the ongoing progress in our society’s response to these problems.

The overall goal of the Commission was to (1) develop an effective consensus for evidence-based, practical, and needed changes to West Virginia’s mental hygiene laws and procedures; and (2) to advance and implement a comprehensive proposal for legislative, executive and judicial action to implement that change.

The members of the Commission represent all those involved in West Virginia’s involuntary commitment process. The membership included: consumers of mental health services, consumers’ family members, consumer advocates, mental hygiene commissioners, a magistrate, a circuit court judge, a prosecuting attorney, a public defender, a sheriff, service providers, representatives from the Department of Health and Human Resources, a

representative from the Governor’s Cabinet on Children and Families, and members of the West Virginia House of Delegates and the West Virginia Senate.

The Commission Process

The Commission held its first meeting on April 7, 1999. At that meeting, three nationally known speakers² presented a history and analysis of the issues plaguing mental health treatment and the involuntary commitment process. The Commission also participated in a “brain-storming” session to identify critical involuntary commitment issues needing urgent and in-depth review. Finally, the Commission approved a work plan that included an intensive period of information gathering and data collection.

The Commission used a number of data collection methods during May and June of 1999 designed to discover the most urgent issues facing the involuntary commitment system. These included conducting public hearings; polling all stakeholders in the system; conducting telephone interviews of consumers and consumers’ family members; and accepting written submissions via the mail and E-mail. A summary of the research methods and results is included in Chapter Three of this report.

During the information gathering process, the Commission heard many different perspectives. The speakers at the forums were very articulate in presenting their concerns, and several shared deeply personal experiences about the involuntary commitment process. The Commission is indebted to the many consumers, family members, employees of the court system, representatives of agencies and community organizations, and others who took the time and effort to respond. A summary of the public forums by city may be found in Appendix B.

¹Recommendation 16.4 from the December 1, 1998 FINAL REPORT of the Commission on the Future of the West Virginia Judiciary.

²Paul Stavis, Director, Law and Psychiatry Center, George Mason University School of Law; Xavier Amador, Associate Professor of Psychology in Psychiatry, Columbia University College of Physicians and Surgeons; and Mary T. Zdanowicz, Executive Director, Treatment Advocacy Center.

Thirteen critical issues were identified by the Commission using the information gathered via the “brainstorming” session at the first meeting and the many comments heard from the public forums, consumer interviews and written comments. These issues became the backbone of the Commission’s review. They included:

1. The sufficiency and appropriateness of commitment procedures and the “dangerousness” standard.
2. The effectiveness and efficacy of transportation procedures.
3. The uses of advance directives and surrogate decision-making.
4. Requiring treatment and medication compliance in and out of hospitals.
5. The uses of, and incentives for, crisis services, preventative services, and aftercare.
6. The adequacy of commitment procedures for, and placement of, the forensic population.
7. Placement and treatment issues for substance abusers.
8. Placement and treatment for children in the mental hygiene system.
9. The uniformity and accountability of service providers, the courts and state agencies.
10. Provider liability and law enforcement liability issues.
11. The sufficiency of training for judicial officers, attorneys, and law enforcement.

12. The adequacy of public awareness and consumer education.

13. The integration and coordination of technology in the mental hygiene system.

The Commission held its second meeting on June 30, 1999. The Commission members were presented with the data collected during the information gathering process. The members were also provided with: (1) an extensive bibliography containing resources and articles relating to involuntary commitment; (2) a summary of the four public forums; (3) a sampling of comments from the forums and the surveys; (4) data collected by the Department of Health and Human Resources’ Office of Behavioral Health Services regarding West Virginia’s mental health facilities; and (5) a summary of involuntary commitment laws from twelve states thought to be progressive in their approach to involuntary commitment. The Commission then broke into the three subcommittees to review their assignments.

The subcommittees were charged with researching, reviewing and making recommendations for the issues identified through the information gathering process.

Issues One through Four addressing **STANDARDS AND PROCEDURES** were assigned to Subcommittee One.

Subcommittee Two addressed the topic of **SERVICES**, found in Issues Five through Eight.

Issues Nine through Thirteen, focusing on **ACCOUNTABILITY, OVERSIGHT, AND EDUCATION**, were the responsibility of Subcommittee Three.

Each subcommittee met for at least four, day-long sessions throughout the summer months and into the fall. At the conclusion of extensive deliberations, each issued a report with recommendations that was distributed to all

Commission members in late September for their review.

The subcommittee reports were taken up by the Commission at its third meeting, on October 12, 1999. After lengthy discussion and debate, the Commission unanimously agreed to all of the recommendations contained in Issues Five through Thirteen. The remaining recommendations, found in Issues One through Four, were discussed and agreed upon by all members at the Commission's last full meeting on November 10, 1999. The Commission's recommendations for reform may be found in Chapter Six of this report.

Throughout the subcommittee process, the Commission's Executive Committee (the Chair, the Subcommittee's chairs and staff) met regularly to ensure that each subcommittee was apprised of the other subcommittees' deliberations and of gaps or inconsistencies in the proposed recommendations. Additionally, an Implementation Committee, chaired by Henry W. "Bucky" Morrow, Jr., was established to consider the methods by which to phase in the Commission's recommendations for reform. A preliminary report of the Implementation Committee is contained in this report in Chapter Five.

This "Final Report" of the Commission on Mental Hygiene Reform was presented to the Supreme Court of Appeals on December 15, 1999.

CHAPTER TWO: INVOLUNTARY COMMITMENT IN WEST VIRGINIA TODAY

Summary of Current Procedures

West Virginia uses an adversarial model of involuntary commitment. Judicial officers, known as mental hygiene commissioners, hear petitions for the involuntary commitment of persons alleged to be mentally ill, mentally

retarded, or suffering from an addiction, and as a result of that condition, are likely to cause serious harm to themselves or others. The subject of the petition is known as the respondent. The petition for involuntary commitment is filed by an

applicant known as the petitioner. Under current law, the petitioner is represented by the county prosecutor. The sheriff's department bears the responsibility for securely transporting the respondent to and from hospitals and hearings.

Many mental hygiene cases begin with an event or crisis that causes the petitioner, often a family member, to believe that the respondent needs to be hospitalized. The applicant files a petition with the circuit clerk's office. Once the petition is filed, the respondent is caught in a process that in many ways resembles a criminal prosecution. The mental hygiene commissioner reviews the petition to determine if the allegations are sufficient to have the respondent taken into custody for an examination by a physician or psychologist. If the allegations meet the test of legal sufficiency, the commissioner issues a "pick up" order that allows the county sheriff's department to transport the respondent to the examination. The commissioner also appoints an attorney for the respondent.

The sheriff's department delivers the respondent to a physician or psychologist for an examination at, or arranged by, a community mental health center. If the physician or psychologist finds evidence of mental illness, mental retardation or an addiction, and evidence that, due to that condition, the respondent is likely to cause serious harm to him or herself or others, the physician or psychologist "certifies" the respondent. If the examination does not take place within three days, then the respondent must be released.

Once the respondent has been certified, he or she must be taken before the mental hygiene commissioner for a probable cause hearing "forthwith." At the hearing, the commissioner decides whether there is probable cause to believe that the respondent is mentally ill, mentally retarded or suffers from an addiction, and is a danger to self or others. If the commissioner finds probable cause, the respondent is taken to a mental health facility for

a detailed examination to be conducted by a staff physician at that facility within five days of admission, Sundays and holidays excluded. If necessary, an agent of the mental health facility must file for the respondent's final commitment within ten days following the date of admission, and a final hearing held within thirty days. If any of these time deadlines are not met, the respondent must be released. The great majority of patients, however, are either stabilized and released from the hospital or converted to a voluntary status before a final hearing.

West Virginia's Involuntary Commitment Statistics

1995 Report

Henry W. "Bucky" Morrow, Jr., a former mental hygiene commissioner in the Eastern Panhandle of West Virginia, reviewed the state of mental hygiene procedure for the year 1995.³ The number of mental hygiene petitions filed that year was 6,201. The median annual caseload per commissioner was fifty-five. The majority of mental hygiene cases (80%) did not proceed beyond the probable cause hearing and, of those that did continue, only five percent actually went to a final commitment hearing. Most mental hygiene petitions (46%) alleged mental illness as a ground for commitment, while thirty-eight percent (38%) claimed drug or alcohol addiction. A very small number (4%), alleged that the respondent was mentally retarded. Seventeen percent of West Virginia's fifty-five counties detained respondents awaiting adjudication in jail, which then, as now, is illegal.

Statistics from the Supreme Court of Appeals

Statistics kept by the Supreme Court's Administrative Office show that 5,462 mental

³ Henry W. Morrow, Jr., *A Profile of Mental Hygiene Courts in the State of West Virginia*, April-July 1995, unpublished article.

hygiene petitions were filed in 1998 (the most recent year for which statistics are available). Cabell County had the greatest number of petitions filed, 1,077, presumably due in part to the presence of Mildred Mitchell Bateman Hospital (formerly Huntington Hospital) in that county. Kanawha County, the State's most populous county, had the second highest number of petitions filed, 662. The third highest with 450 petitions filed was Lewis County, home of the State's other psychiatric hospital, William R. Sharpe, Jr. Hospital. The median number of petitions filed per county statewide is about 40 per year.

In Fiscal Year 1998, the Supreme Court employed 102 mental hygiene commissioners around the State. The Court paid commissioners' fees totaling \$865,540; however, an unknown portion of these fees may be attributed to guardianship proceedings. On average, mental hygiene commissioners were paid approximately \$9,000 per year for their services. Only fifteen percent of mental hygiene commissioners were paid more than \$20,000 per year.

Public Defender Statistics

In Fiscal Year 1998, Public Defender Services reported that 4,979 of their 28,702 total *appointed counsel* claims were "mental hygiene claims." Public Defender Services paid \$511,581 to lawyers appointed to represent indigent respondents in involuntary commitment proceedings. That payment represents about five percent of the Public Defenders Services' total annual budget for appointed counsel services (\$14,215,126.37). In addition, *state-employed public defenders* spent approximately 1,100 hours on mental hygiene cases in 1998. At \$45 per hour, the State spent an additional \$50,000 on respondent representation.

Prosecutor Statistics

The Commission was unable to garner any statistics from the State's prosecutors

regarding the number of hours they spent representing petitioners in mental hygiene proceedings.

Sheriff Statistics

Despite the many complaints received at the Commission's public forums regarding the amount of time sheriffs spend transporting respondents, there was a similar dearth of statistical reporting on the cost of transporting respondents.

Department of Health and Human Resources Statistics

State Hospitals

The State of West Virginia operates two psychiatric hospitals, Mildred Mitchell Bateman Hospital in Huntington, and William R. Sharpe, Jr. Hospital in Weston. Together these facilities can house 240 persons: 90 at Bateman and 150 at Sharpe. However, on average, over forty of Sharpe's beds are used by forensic patients. The forensic population is made up of those criminal defendants found incompetent to stand trial or "not guilty by reason of mental illness."

The State's two psychiatric hospitals accepted 1,662 probable cause admissions in 1998. The petitioner is most often a family member (40%) or a community mental health center staff member (22%). Petitions were also filed by law enforcement personnel (10%) and emergency room staff (7%).

Respondents are most often evaluated and certified by a psychologist (56% of the time). Examinations are also conducted by psychiatrists (21%), other doctors (20%), and on rare occasions, doctors of osteopathy (1%).

In 1998, roughly half of the probable cause admissions were persons who had previously been admitted to a state psychiatric hospital.

The most common diagnosis was “mental illness” (60% of those patients whose records indicated a diagnosis). An additional 33% had a dual diagnosis of “mental illness and substance abuse.”

Of the patients admitted to state-operated facilities in 1998, 28% were released within 10 days, 55% were released within 20 days, and 79% were released within 30 days. This is remarkably different from the average fifteen-year stay common in 1974 when the current mental hygiene laws were enacted.

Other Treatment Facilities

There are fourteen community mental health centers in West Virginia that serve persons with mental illness.⁴ All but one operate residential facilities.

Additionally, there are thirteen substance abuse treatment facilities, six of which are residential. These six facilities can house up to 203 adults and forty adolescents. None of these facilities are secure (*i.e.*, locked).

Children can be involuntarily committed at any of ten different mental health centers in the State. Although these facilities can house a total of 161 children, many of those placements are designated for specific populations, such as children under final commitment or with substance abuse problems.

⁴There are actually four more facilities, but they serve only people with mental retardation and/or developmental disabilities.

CHAPTER THREE: DISCOVERING THE ISSUES

To discover the most critical issues facing West Virginia's involuntary commitment system, the Commission on Mental Hygiene Reform used a number of data collection methods during May and June of 1999. These included conducting public hearings, surveying all judicial officers and court personnel, polling other stakeholders in the system, conducting telephone interviews of consumers of mental health services and consumers' family members, and accepting written submissions via the mail and E-mail.

In total, the Commission received comments from more than 240 people.

Public Forums

In compliance with the Supreme Court's mandate that the Commission solicit and evaluate the views of those who utilize or participate in the involuntary commitment system, four public forums were held throughout the State during May 1999. Hearings were held in Martinsburg, Morgantown, Beckley and Charleston. Commission members served as moderators, and transcripts were made of the proceedings. One hundred and fifty-one people attended the hearings and fifty-three individuals, representing a diverse array of people, professions and interests, made oral presentations to the Commission. The speakers included fourteen consumers of mental health services, seven parents of consumers, three consumer advocates, three prosecutors, a public defender, three sheriffs, a county commissioner, three mental hygiene commissioners, a Supreme Court justice, and thirteen service providers including psychiatrists, psychologists, and crisis workers. Some of the most frequently heard comments are listed below.

A **parent** said: "We need to decriminalize the process. We need post-hospitalization follow-up and aftercare."

Another **parent** said: "Why do we have to wait until someone is swinging a knife at his mother before somebody can intervene? We need to look at the 'dangerousness' standard."

A **consumer of mental health services** said: "Treatment in the community is much less expensive than hospitalization."

A **consumer advocate** said: "People would like to see an observation period, where maybe the problem can be solved before we commit to a state hospital. We also need peer assistance, crisis intervention, respite care, and advance directives."

A **psychiatrist** said: "We need clearer rules about what we can do in emergencies. The forthwith hearing and the 10-day requirements are unworkable."

A **sheriff** said: "People should not be caged up like animals in the back of our cars."

A **county commissioner** said: "We need a place locally to take care of people. The trip to Weston is too far and expensive. A hearing costs us hundreds of dollars."

A **prosecutor** said: "We need a system with less lawyers and more medically-trained people."

A **probation officer** said: "There must be more training for commissioners. Juveniles are being lost in the system and need facilities."

A **mental health care worker** said: "Forensics is placing a huge burden on state hospitals."

A **mental hygiene commissioner** said: "Hospitals are worried about liability in releasing someone, especially in close calls, and pass the buck to the mental hygiene commissioner."

A more complete sampling of comments may be found in Appendix C.

Court Personnel Survey

In order to benefit from the accumulated experience and expertise of the approximately one thousand individuals who work in the court system, the Commission distributed open-ended surveys to all Court employees with their end-of-May 1999 paycheck. Recipients were asked to list (a) the three most important issues facing the mental hygiene system, and (b) the three changes they would make to improve the system. The survey was to be answered anonymously -- the employee was asked to list only his or her job title and whether they had responsibilities within the mental hygiene system. A copy of the court employee survey instrument may be found in Appendix D.

Of those individuals surveyed, sixty-three responded, including judges, family law masters, magistrates, probation officers, court reporters, circuit and magistrate clerks, and Supreme Court staff attorneys.

Many issues were raised which concerned the practices and procedures of the current involuntary commitment system. Some of the common themes included:

- The need to decriminalize the process.
- Problems with transportation by law enforcement officers.
- The lack of expediency of commitment hearings.
- The lack of availability of crisis services and service providers after-hours.
- The lack of services for juveniles.

- The need for alternative treatments when involuntary commitment is not necessary.
- The need for follow-up care.
- The lack of local screening and treatment facilities.
- The need for training for attorneys, health care providers, and law enforcement officers.
- The need for uniform criteria for commitment.

Stakeholder Open-Ended Survey and Issue Ranking

Stakeholders in the involuntary commitment system other than court employees were also surveyed. These included sheriffs, county commissions, prosecutors and public defenders, local presidents of the West Virginia Mental Health Consumers Association, community mental health center directors, local presidents from the National Alliance for the Mentally Ill (NAMI), mental hygiene commissioners and various mental health associations. More than one hundred persons responded to the survey. A copy of the "Stakeholder" survey instruments may be found in Appendix D.

Those polled were also asked to list three problems with the present mental hygiene system and to list three improvements. Commonly heard responses from the 110 respondents included the following:

Sheriffs said:

- "There should be at least one secure facility in each county designated for temporarily holding respondents."

- “Sheriffs are not properly trained to deal with persons with mental illness.”

Prosecutors said:

- “Substance abuse facilities for residential treatment are extremely limited.”
- “We have no place to put juveniles who need treatment.”
- “Prosecutors should not be part of the system until after the ‘forthwith’ hearing.”
- “Implement a system to keep ‘revolving door’ patients on their medications.”

Mental Hygiene Commissioners said:

- “We need uniform training on an annual basis.”
- “There is a lack of procedural uniformity between counties.”
- “We need to be able to provide treatment before a person becomes dangerous.”
- “Require every mental health facility that contracts with the State to provide twenty-four-hour crisis stabilization.”

Mental Health Services Providers said:

- “Change the ‘dangerousness’ standard to a ‘need for treatment’ standard.”
- “The ‘forthwith’ hearing standard does not provide adequate time for a proper evaluation.”
- “Implement standardized training for involved participants.”

Consumer Advocates said:

- “Ensure treatment with dignity.”
- “We need equal health insurance coverage, or parity, for those with mental illness.”
- “Independent advocates should be available for all hearings.”

In addition to the open-ended survey, a second survey form was sent to this group of stakeholders. The second form listed the thirteen issues that were heard most frequently at the public forums (see Chapter One). The recipients were asked to select the five most critical issues of the thirteen listed, and then to rank them from one (most urgent) to five. The thirteen issues ranked in order of urgency, with number one being the most urgent, were:

ISSUES LISTED IN ORDER OF URGENCY	
First	The uses of, and incentives for, crisis services, preventative services, and aftercare.
Second	The effectiveness and efficacy of transportation procedures, the quality and quantity of holding and detention facilities, and the timing and locations of hearings.
Third (tie)	The sufficiency and appropriateness of commitment procedures and the “dangerousness” standard.
Third (tie)	Placement and treatment issues for substance abusers.
Fourth	The uniformity and accountability of service providers, the courts and state agencies.
Fifth	Placement and treatment of children in the mental hygiene system.
Sixth	Requiring medication compliance in and out of hospitals.
Seventh	The adequacy of commitment procedures for, and placement of, the forensic population.
Eighth	The sufficiency of training for judicial officers, attorneys, and law enforcement.
Ninth	The adequacy of public awareness and consumer education.
Tenth	Provider liability and law enforcement liability issues.
Eleventh	The uses of advance directives and surrogate decision-making.
Twelfth	The integration and coordination of technology in the mental hygiene system.

The scores were also tabulated separately for the following groups: sheriffs, prosecuting attorneys, mental hygiene commissioners, mental health services providers; and advocates. Some issues appeared to be more important for particular stakeholders. For example, sheriffs ranked “transportation” as the most important issue while prosecutors viewed “commitment standards and procedures” as most important. Mental health services providers ranked “the use of, and incentives for, crisis services, preventative services, and aftercare” to be most urgent; consumer advocates agreed. Finally, mental hygiene commissioners ranked the “placement and treatment issues for substance abusers” as the most urgent issue facing the mental hygiene system.

Written Submissions

The Commission encouraged written submissions, via the mail and through the Supreme Court’s Web site. At each of the public hearings, business cards and pre-addressed

envelopes were available so that those who did not wish to speak publicly could still contribute comments. Eleven written submissions were sent by ten people. Two submissions were received via E-mail from different senders. Comments were submitted from consumers, attorneys and family members.

The most common issues heard included:

- The need to decriminalize the commitment process.
- Problems with scheduling after-hours hearings.
- The lack of availability and accessibility to treatment such as follow-up care.

Telephone Interviews

The Commission’s staff conducted interviews with consumers, family members, and NAMI members during May and June 1999 who

expressed a desire to share their opinions but did not want to appear at one of the public forums. Seven people were interviewed about their experiences with West Virginia's involuntary commitment system.

Common themes among those interviewed were:

- The need for appropriate assisted living programs.
- The need for parity or equal insurance coverage for physical and mental illness.
- The lack of facilities in rural areas for local care and crisis management.
- The difficulty of finding placement for family members who are both physically and mentally ill.

CHAPTER FOUR: THE REFORM PROPOSAL

The Commission on Mental Hygiene Reform believes that the time has come to bring our system of involuntary commitment into conformity with the modern-day treatment of persons with mental illness. We envision a “civil commitment” system that preserves due process, yet focuses on treatment; that provides appropriate and effective services before, during, and after commitment; and that is accountable to the people that use the system and to the entities that fund it. The bedrock of this reformed system is service. Without first filling the gap in needed services, many of the Commission’s recommendations will have little effect. The focus of the reformed system is the consumer. Meeting the needs of consumers was the polestar that drove our deliberations.

In a reformed system:

The “dangerousness” standard will be modified to include a “need for treatment” standard.

The “dangerousness” standard drives the criminalization of the involuntary commitment system and the people who use it. Moreover, research suggests that early treatment may lead to better outcomes, while delaying treatment leads to worse outcome. Therefore, requiring a person to become “a danger to self or others” before involuntary treatment can be rendered may result in worsening medical prognosis.

In addition to the current grounds for involuntary commitment, the revised standard will include a “need for treatment standard.” The need for treatment standard will allow a person to be involuntarily committed when they are a harm to themselves because they are unable to satisfy “the need for nourishment, personal or medical care, shelter, self-protection or safety” and no less restrictive treatment alternative is acceptable.

A clinical model will replace the current adversarial system.

In the reformed system, the current statutes will be revised to allow a licensed psychologist or psychiatrist to involuntarily commit a person who meets the “revised serious harm” standard through an “emergency certification” procedure, thus eliminating the “probable cause” hearing.

The community mental health centers (or other appropriate Department of Health and Human Resources mental health services providers) will serve as the “gatekeepers” who conduct or approve evaluations.

Peer and patient advocates will be available to the person subject to commitment throughout the emergency certification and commitment process.

Patients under final commitment will participate in statutorily-mandated progress reviews every ninety days.

Statutory language will no longer contain archaic terms. For example, the term “mental hygiene” will be replaced with modern terms such as “mental health” or “behavior health.”

Sheriffs will be encouraged to contract out transportation duties to entities trained to work with persons in crisis.

In the reformed system, sheriffs will be encouraged to train part-time county employees to transport persons in crisis or to contract with outside entities who are both trained in transporting persons in crisis and who have proof of sufficient liability insurance to address any liability to respondents or others. Those sheriffs who contract with entities that meet these standards will be relieved of any responsibility

for the care and custody of persons subject to commitment proceedings.

Local holding and treatment facilities will decrease the need for repeated long-distance transportation of persons in crisis.

To eliminate multiple long-distance trips to the State's psychiatric hospitals, patients will be evaluated and treated in local secure facilities so that known service providers, family members and friends can continue to assist and support the patient.

Advance directives will be strongly encouraged, facilitated, and used to make treatment decisions.

In the reformed system, consumers of mental health services will be encouraged to create "advance directives for mental health care" that will be used to make treatment decisions should the consumer be determined unable to make those decisions. Acting in accordance with an advance directive will be evidence of good faith in an action for damages.

When appropriate and necessary services are in place, conditional commitment to less than full hospitalization will be used as a less restrictive alternative.

Persons on "convalescent status" release will be afforded counsel if a mental health facility seeks to recommit. A process of formal review for those persons on convalescent status release will be established that involves the patient, his or her treating physician and treatment team and peer advocates.

Private funds and nonprofit agencies will work with State dollars to provide necessary community-based services.

Private insurance dollars resulting from the legislation creating insurance parity for mental health treatment, and the work of

volunteers and nonprofit agencies, already at work in a great many states, will help fill the void for needed services.

Appropriate and effective community-based services will be available from the outset of the commitment process through aftercare.

The reformed system will provide a continuum of accessible transitional services from preventive services in the community, through crisis intervention, to after and long-term care.

Community-based mobile crisis intervention teams and assertive community-based treatment programs will be available statewide.

Community-based mobile crisis intervention teams and assertive community-based treatment programs are already at work in a few of West Virginia's counties. In the reformed system, these model programs will be funded so that they may continue to divert commitments and thereby save money.

Services will meet the needs of all consumers including forensic patients, children, substance abusers, and all persons subject to commitment proceedings.

In the reformed system, the Legislature will adopt a plan to provide adequate and appropriate facilities and treatment for forensic patients, children and substance abusers.

- Long-term forensic patients will be afforded automatic periodic reviews.
- A system of diagnosis and treatment will be implemented for inmates at jails and prisons across the state.
- Treatment providers will include family members in treatment and discharge plans.

- Legislation will be enacted to ensure that parents will not have to relinquish or transfer custody of their children to obtain needed mental health treatment for these children, including: parity legislation; legislation allowing court-supervised voluntary placement and care agreements without custody transfers; and, legislation giving courts the ability to order treatment services when parents are financially unable to provide them and which are necessary to prevent custody transfer or relinquishment solely for financial reasons.
- West Virginia's schools will have increased involvement in mental health screening and early intervention.
- The State will establish a mental health screening and services program in civil abuse and neglect cases and in juvenile justice system cases.

The system will be accountable to itself, and to all three branches of government.

- A Statewide Commission will be created to lead an ongoing process of evaluation, training, and improvement.
- Community mental health centers will become the single point of entry to the involuntary commitment system and will serve as the jurisdiction for all data collection, planning, training and evaluation programs associated with involuntary commitment.
- To improve the delivery of services, each community mental health center will conduct semi-annual meetings of key participants in the involuntary commitment process in the center's service area.
- The Department of Health and Human Resources' Office of Behavioral Health

Services and the Supreme Court of Appeals will substantially and significantly increase their oversight functions.

- Treatment standards will be established for the community mental health centers.
- The Supreme Court will establish standards for attorneys representing persons subject to commitment.

Fear of liability will not drive commitments.

The judicial immunity provided to mental hygiene commissioners in the current system will be transferred to decision-makers in the reformed system. Good faith immunity will be provided to other commitment system participants for good-faith actions performed in conformance with system-wide standards.

Public Awareness and Consumer Education will be increased.

Using media campaigns and education materials, the Department of Health and Human Services' Office of Behavioral Health Services will increase public awareness and consumer understanding of the reformed system.

All participants will be regularly trained.

The community mental health centers will host semiannual, mandatory, regional training sessions for all participants in the commitment system including publicly funded advocates, consumers and family groups.

Attorney eligibility for publicly-funded appointment to represent persons subject to commitment will be conditioned upon the attorney's participation in annual, multi-disciplinary training sessions.

Video conferencing and electronic communication will facilitate medical consultations, discharge planning, record

keeping, and family involvement, and will significantly decrease transportation costs.

CHAPTER FIVE: IMPLEMENTATION PROPOSAL

It was the Commission's responsibility to recommend the best possible means of reforming the State's mental hygiene laws, policies, practices, and procedures. The result, summarized in Chapter Four of this Report, is a comprehensive reform plan that balances due process with the need for humane, effective treatment services. These are not quick or easy solutions but we chose them, after much consideration and lengthy debate, because we believe they are the right thing for the State and her citizens.

The Commission's sixty-three recommendations range from dramatic proposals for change to the structure and approach of the involuntary commitment process to minor refinements of the system. Twenty-two of the recommendations are directed to the West Virginia Legislature. Twelve go to the Supreme Court of Appeals. Another nineteen recommendations will be the responsibility of the Department of Health and Human Resources. Other recommendations are directed to the State's community mental health centers and psychiatric hospitals, county commissions and sheriffs, the Department of Corrections, the Regional Jail Authority, the Department of Juvenile Services, West Virginia's schools, West Virginia Continuing Legal Education, and the West Virginia Bar. A list of the recommendations by responsible party may be found in Appendix F of this report.

Some of the recommendations can be accomplished immediately, while others will require a phase-in plan over months or even years. Many of the recommendations will require the coordination of efforts between a number of agencies and organizations.

Implementing the reform plan will take the leadership, active support, and the persistence of those who demand an involuntary commitment

system that is fair, treatment-oriented and accountable.

Several of the Commission's recommendations can be accomplished within the next year without incurring major expense. A list of those recommendations may be found in Appendix F.

Those recommendations that will take longer to implement will likely be those that come with a fiscal note. Fifteen of the Commission's sixty-three recommendations will require fiscal notes (noted by dollar signs in Appendix F). During our deliberations, we were ever mindful of the fact that money is a key factor, and often a critical sticking point, in the reform of any system. Although additional funding will be necessary to implement the reformed system, these funds need not come solely from the State's coffers. Private dollars should and must be added to the system. Existing funding must be used more effectively to provide better services which will, in turn, save money.

We believe that the reformed system will save dollars. Better and more available services, particularly in the form of mobile crisis capacity, will decrease the number of involuntary commitments. Pilot projects, such as the three-year-long mobile crisis team project at East Ridge Health Systems, bear this out.

Fewer commitment proceedings mean lower procedural costs for many different stakeholders in the involuntary commitment system. The Supreme Court will save mental hygiene commissioner fees. County commissions will save money in sheriffs' transportation costs, circuit clerk time, and decreased prosecutor hours. Public defenders and appointed counsel will take fewer State dollars in fees.

The money that is saved from procedural reform can be put back into the system in the form of desperately needed services. Providing better services during periods of crisis and after a person is stabilized will again save money by decreasing the number of hospitalizations for “revolving door” patients.

In addition to saving money by decreasing the number of commitment proceedings and subsequent commitments, the enactment of parity legislation for the treatment of serious mental illness will bring needed private dollars into the system. Furthermore, cooperative team work between public and private entities, including nonprofit or volunteer entities, will also help improve services while keeping expenditures to a minimum.

The Implementation Committee of the Commission on Mental Hygiene Reform has begun working with the Department of Health and Human Resources and various subcommittees of the West Virginia Legislature to consider an implementation plan. We are aware that reform of our State’s involuntary commitment system will take time and much effort. We are committed to providing both to bring about this desperately needed reform.

CHAPTER SIX: REPORTS AND RECOMMENDATIONS

STANDARDS AND PROCEDURES

- Issue 1: Involuntary Commitment Standards and Procedures
- Issue 2: Transportation Procedures
- Issue 3: Advance Directives and Surrogate Decision Making
- Issue 4: Requiring Treatment and Medication Compliance In and Out of Hospitals

II. SERVICES

- Issue 5: Use of, and Incentives for, Crisis Services, Preventative Services and Aftercare
- Issue 6: Adequacy of Commitment Procedures For, and Placement Of, the Forensic Population
- Issue 7: Treatment and Placement Issues for Substance Abusers
- Issue 8: Treatment and Placement of Children in the Involuntary Commitment System

III. ACCOUNTABILITY, OVERSIGHT AND EDUCATION

- Issue 9: Uniformity and Accountability of Service Providers, the Courts, and State Agencies
- Issue 10: Provider Liability and Law Enforcement Liability Issues
- Issue 11: Public Awareness and Consumer Education
- Issue 12: Sufficiency of Training for Judicial Officers, Attorneys, and Law Enforcement
- Issue 13: Integration and Coordination of Technology in the Involuntary Commitment System

I. STANDARDS AND PROCEDURES

Issue 1: Involuntary Commitment Standards and Procedures

Issue 2: Transportation Procedures

Issue 3: Advance Directives and Surrogate Decision Making

Issue 4: Requiring Treatment and Medication Compliance In and Out of Hospitals

ISSUE 1: INVOLUNTARY COMMITMENT STANDARDS AND PROCEDURES

A. The “Serious Harm” Involuntary Commitment Standard

Before a person with mental illness, mental retardation, or an addiction can be involuntarily committed for hospitalization and treatment, West Virginia law requires that there be proof that the person is “likely to cause serious harm to himself or herself or to others if allowed to remain at liberty[.]” *W.Va. Code*, 27-5-2 [1992].

The “serious harm” standard of proof, commonly called the “dangerousness” standard, drives the “criminalization” of the involuntary commitment process. When a person with mental illness is legally declared to be “dangerous,” the person is treated in ways nearly identical to a criminal defendant.

Many persons with mental illness cannot afford routine mental health care, and do not recognize the existence or extent of their illness. Before receiving treatment, persons with a mental illness must often spiral to the depths of their illness, to a level that they are declared, in a legal proceeding, likely to cause serious injury to themselves or others. Currently, the legal proceeding involves a judge or mental hygiene commissioner, a prosecutor, and a defense attorney. Throughout the legal proceeding, the person with a mental illness carries a legal status

that he or she is likely to cause serious harm and is treated accordingly. The person, known as a respondent, is transported by a sheriff’s deputy, sometimes in handcuffs. Community mental health centers may refuse to treat these persons out of fear of liability for mishandling a “dangerous” person.

During the Commission’s information gathering process, the “criminalization” of mental illness as a result of the “serious harm” standard was identified as one of the most significant problems with the existing involuntary hospitalization process.

West Virginia’s “serious harm” standard was adopted by the West Virginia Legislature in response to the West Virginia Supreme Court of Appeals’ decision in *State ex rel. Hawks v. Lazaro*, 157 W.Va. 417, 202 S.E.2d 109 (1974). *Hawks* held that West Virginia’s previous involuntary commitment law was unconstitutionally vague, because it failed to provide specific standards for involuntary commitment to a mental institution. The *Hawks* opinion said that involuntary hospitalization and treatment was constitutionally permissible (1) to prevent an ascertainable injury to a person, and (2) if hospitalization and treatment would offer a reasonable likelihood of ameliorating an illness or condition that would lead to the injury.

The current “serious harm” standard for involuntary commitment to a mental health facility is set forth in *W.Va. Code*, 27-1-12:

“Likely to cause serious harm” refers to a person who has:

(1) A substantial tendency to physically harm himself which is manifested by threats of or attempts at suicide or serious bodily harm or other conduct, either active or passive, which demonstrates that he is a danger to himself; or

(2) A substantial tendency to physically harm other persons which is manifested by homicidal or other violent behavior which places others in reasonable fear of serious physical harm; or

(3) Complete inability to care for himself due to mental retardation; or

(4) Become incapacitated. . . .

West Virginia’s current serious harm standard is outdated and should be revised to reflect modern realities. The long-term warehousing of thousands of persons with mental illness in “asylums” is a thing of the past. In 1974, the *Hawks* opinion found that the average length of stay for involuntarily committed patients in West Virginia institutions was 15.91 years; today that figure is closer to 15 days. At the time of *Hawks*, on any given day there were thousands of involuntarily committed patients in state psychiatric hospitals; today, the average is less than 250.

At the time of the *Hawks* decision, the consequences of involuntary commitment to a “mental institution” were profound, and the

medical benefits were highly questionable. Then, substantial procedural protections were needed to prevent unnecessary, lengthy, and often ineffective hospital stays. In the twenty-five years since *Hawks* was decided, there has been a revolution in the understanding and treatment of mental illness, including the use of modern medications that can dramatically ameliorate the symptoms of many mental illnesses.

Modern medicine recognizes that early intervention and treatment of acute or crisis episodes of mental illness leads to better outcomes, and delaying treatment leads to worse outcomes. Modern drugs can quickly arrest acute episodes of mental illness and the consistent use of medication can help prevent recurrence. Prompt intervention and treatment can prevent further deterioration that can occur if the symptoms are left untreated. Early intervention is also more cost-effective, because the illness is treated at a less advanced stage.

West Virginia’s current legal definition of “serious harm” is vague, leading to confusion and uncertainty as to when appropriate intervention is necessary. The current commitment standard focuses on the antiquated concept of “dangerousness” and thereby fails to explicitly encompass persons with mental illness whose judgment is so impaired that they cannot effectively provide their basic human needs. It also does not explicitly encompass a person with mental illness who has received court-ordered hospitalization in the past, and is exhibiting similar behavior that precipitated the previous court-ordered hospitalization. The Commission repeatedly heard testimony that persons with mental illness, who desperately needed treatment, were denied court-ordered hospitalization simply because they had not yet deteriorated to a point where they were considered “dangerous.”

The Commission therefore recommends the following:

1.1 The LEGISLATURE should amend *W.Va. Code*, 27-1-12 [1992], the statutory definition of “likely to cause serious harm,” and adopt language that incorporates a “need for treatment” standard.⁵ The current definition should be amended to state that:

a. To be involuntarily hospitalized for treatment, an individual must be exhibiting behaviors consistent with a mental disorder or addiction that is found in the American Psychiatric Association’s current *Diagnostic and Statistical Manual of Mental Disorders*. However, disorders that are manifested only through antisocial and/or illegal behavior (such as pedophilia) should be excluded from the involuntary hospitalization process.

b. A likelihood of serious harm to others may be shown by establishing that, as a result of a mental illness:

(1) the person has inflicted or attempted to inflict bodily harm on another; or

(2) the person, by threats or actions, has placed others in reasonable fear of physical harm to themselves; or

(3) the person, by actions or inactions, has presented a danger to others in the person’s care.

c. A likelihood of serious harm to the person may be shown by establishing that, as a result of a mental illness:

(1) the person has threatened or attempted suicide or serious bodily harm; or

(2) the person has behaved in such a manner as to indicate that the person is unable, without supervision and the assistance of others, to satisfy the person’s need for nourishment, personal or medical care, shelter, or self-protection and safety, so that it is probable that death, substantial physical bodily injury, serious mental decompensation or serious physical debilitation or disease will ensue unless adequate treatment is afforded.

d. After review of alternative treatments with the individual, there is no less equally effective treatment available.

e. In making the involuntary treatment determination as part of the “emergency certification” process, the judicial, medical, psychological and other decision-makers may utilize all available psychosocial, medical and psychiatric history that is relevant to a current situation in addition to the individual’s current overt behavior without regard to strict rules of evidence.

⁵The Commission examined the statutory “need for treatment” language used by many other states, particularly those Vermont, *Vt. Stat. Ann.*, title 18, § 7101(17)[1977]; Minnesota, *Minn.Stat. Ann.* § 253B.02(17); and Nebraska, *Neb.Rev.Stat.* § 83-1009.

Commentary: The current definition of “likely to cause serious harm” in *W.Va. Code*, 27-1-12(a) allows an individual to be involuntarily hospitalized because of “other conduct, either active or passive, which demonstrates that he is

dangerous to himself[.]” This vague phrase is sometimes interpreted by mental hygiene commissioners as allowing a person to be committed due to an inability to meet basic living needs. Other mental hygiene commissioners refuse to consider need for treatment, and instead will commit only when the person threatens actual, physical harm to him/herself or others.

By adopting the above language, courts and service providers will finally receive specific guidance to determine whether a person with mental illness has a need for treatment.

B. Involuntary Commitment Procedures

A summary of the State’s current involuntary commitment procedure may be found in Chapter Two of this report.

The comments received by the Commission about the current involuntary commitment procedure -- from every stakeholder group -- were overwhelming and unanimous that the current process is costly, unnecessarily legalistic, and often therapeutically counterproductive.

It appears that West Virginia is the only state in the nation that requires a “forthwith” hearing before a person in an acute mental health crisis may be treated. A majority of states allow for “emergency certification” thereby allowing an individual to be examined and treated on an emergency basis for several days before legal proceedings occur. All of these states appear to adequately protect the rights of persons with mental illness.⁶ Compared to West Virginia’s

⁶For example, Vermont, a state with demographics similar to West Virginia, allows a person with mental illness to be treated on an emergency basis for up to five days before a judicial hearing must be held; (continued...)

current system, every other state has a more decriminalized, less arduous and legalistic procedure. All other states make the initial hospitalization procedure much more of a medical decision.

When a person with mental illness receives speedy treatment and medication for an acute mental health crisis, the debilitating effects of the mental illness are often quickly reversed. Often, within a matter of days after receiving treatment, the patient is able to voluntarily consent to further treatment, eliminating the need for further court proceedings for involuntary hospitalization.

C. Application of the Standard

West Virginia’s current involuntary commitment statutes provide for the involuntary hospitalization of individuals with mental retardation and developmental disabilities. The Commission believes that the Legislature should remove mental retardation, developmental disabilities, and other similar mental impairments from existing commitment statutes.

Current medical opinion is that individuals with mental illness are just that: ill. Like any disease, a mental illness can be treated and many of its effects reversed.

However, mental retardation is not an illness. It is a permanent physical condition that cannot be reversed, and its principal manifestations are not symptoms that can be alleviated by treatment. Thus, “treatment” via involuntary hospitalization will not result in any alteration or improvement in the patient’s condition. However, where there is a dual

⁶(...continued)
a hearing is held only if the person requests a hearing. Otherwise, the court must hold its first hearing within 10 days of the person’s involuntary admission for treatment. See *Vt.Stat.Ann.*, Title 18, § 7508 [1977] and § 7615 [1977].

diagnosis of mental retardation and mental illness, the fact that a person has mental retardation should not be an impediment to involuntary commitment proceedings.

The Commission therefore recommends:

- 1.2** The **LEGISLATURE** should amend the current involuntary hospitalization statutes to adopt a modified, clinically-based process, like that followed in other states.⁷
- 1.3** The **LEGISLATURE** should amend the current statutes to remove the phrase “mental hygiene,” and adopt modern terms such as “mental health,” “behavioral health,” and/or “civil commitment.” For example, the “mental hygiene commissioner” should be renamed the “mental health officer.”
- 1.4** The **LEGISLATURE** should remove from the involuntary hospitalization system persons with a sole diagnosis of mental retardation, developmental disabilities, or any other similar conditions where hospitalization and treatment would be ineffective in stabilizing and improving behavior.
- 1.5** The **LEGISLATURE** should amend the current involuntary hospitalization procedural statutes, with the following general components:
 - a.** Any adult (such as a family member, physician, or law enforcement officer) with personal knowledge that a person has a mental illness or is

addicted may initiate the involuntary emergency treatment of the person by filing a “Request for Evaluation” with the circuit clerk’s office.

- b.** If the “Request for Evaluation” asserts facts which, if true, would meet the revised “serious harm” standard, a judicial officer or mental health officer may issue a “pickup order” to have the respondent transported for an emergency mental health evaluation. As with existing procedure, the pick-up order would require the sheriff’s department to detain the respondent, and transport him or her to a community mental health center for evaluation.
- c.** The Department of Health and Human Resources should be given the authority to designate community mental health centers or other Department-designated providers to serve as “gatekeepers” who conduct or approve evaluations.
- d.** A Department-designated mental health service provider must conduct, or must approve, an emergency mental health evaluation of a respondent. The examination may be conducted at any location by a physician or a licensed psychologist, but must be conducted as soon as possible. If in the physician’s or licensed psychologist’s opinion the respondent meets the revised “serious harm” standard, the physician or licensed psychologist may sign an “emergency certification”

⁷The Commission determined that Vermont’s involuntary commitment statutes provide an excellent model that balances clinically-based treatment concerns with due process protections. See *Vt.Stat.Ann.*, Title 18, §7101 *et seq.*, §7501 *et seq.*, and §7601 *et seq.*

indicating that the respondent should be admitted to a course of emergency treatment and observation at a mental health treatment center. The Department-designated provider must file the “e m e r g e n c y certification” with the mental health officer.

- e. The mental health officer must review the “emergency certification” to determine if probable cause exists that the respondent meets the revised “serious harm” standard. If the revised “serious harm” standard is met, the mental health officer may order that the respondent be admitted to a mental health treatment facility for treatment and observation.
- f. The Department of Health and Human Resources, in collaboration with the Department-designated provider and advocacy groups, should facilitate the development and support for peer advocate services that may be used in conjunction with emergency certification procedures. Where such services are available, the Department-designated provider and the mental health officer should facilitate and permit, the participation of approved peer advocates in the emergency certification process, where such participation is feasible and not unduly delaying. However, emergency certification may

occur without the participation of peer advocates.

Commentary: A “peer advocate” is a consumer of mental health services who volunteers to assist a person through the commitment process. A “patient advocate” is an individual effective at consumer advocacy who is paid by the State for providing consumer advocacy services.

- g. Once a person has been committed, a patient advocate must be afforded an opportunity to consult with the individuals treating the patient to ensure that the patient receives the most effective, least restrictive, least intrusive form of treatment. The patient has the right to accept or refuse the assistance of the patient advocate. After consultation with the patient, the patient advocate may advise the mental health officer of any improprieties with the “emergency certification” process, and may request that the mental health officer appoint counsel to represent the patient.
- h. The right of a patient to a writ of *habeas corpus* must be preserved.

Commentary: Current regulations issued by the Department of Health and Human Resources establish protocols for State mental health treatment facilities to follow before involuntarily administering treatment. As discussed elsewhere in this report, the Commission recommends that the Legislature authorize the Department to establish similar protocols to allow private facilities to administer treatment when a patient refuses necessary treatment.

- 1.6** The **LEGISLATURE** should maintain the existing statutory requirement that a facility must certify that a respondent is mentally ill or addicted within five days of admission, and move for commitment within 10 days. If the treatment facility requests full commitment, the mental health officer must appoint counsel to represent the patient. Furthermore, the procedure for having a full hearing concerning commitment within 30 days should be retained. As with existing statutes, a patient may not be involuntarily committed for a period in excess of two years.
- 1.7** For those patients under final commitment, the **LEGISLATURE** should establish a process of formal review of the patient's progress that involves the patient, the patient advocate, and the patient's treating physician and treatment team. A review should be conducted at least every 90 days, to ensure the patient is complying with conditions established in the commitment process, to determine if a less restrictive alternative course of treatment can be adopted, and to ensure that the mental health treatment facility is providing the necessary medications and treatment.

ISSUE 2: TRANSPORTATION PROCEDURES

The transportation of respondents in the mental hygiene system is a task primarily performed by the county sheriff where the respondent resides. *W.Va. Code, 27-5-1(d)* [1992] requires the sheriff, upon a written order by a circuit court or mental hygiene commissioner, to take into custody and transport the respondent "to and from the place of hearing and the mental health facility." The sheriff is also charged with maintaining custody and control of the respondent while waiting for involuntary

commitment hearings to be convened and while such hearings are being conducted. The sheriff must "provide immediate transportation to or from the appropriate mental health facility or state hospital." *W.Va. Code, 27-5-10(a)* [1993].

Additionally, if the respondent is "violent or combative," *W.Va. Code, 27-5-1(e)* charges a sheriff with the responsibility to maintain custody over the respondent at the mental health care facility until any evaluations are completed.

Alternatively, the mental health care facility may provide security to maintain control over the respondent, and the facility may bill the costs of those security services to the county commission. The mental health care facility may also, under *W.Va. Code*, 27-5-10 [1993], enter into an agreement with the county commission and the local emergency medical service agency to provide an alternative form of transportation for respondents. However, the sheriff retains the responsibility, including liability, for providing security for respondents unless the transportation agreement clearly shifts “responsibility for the [respondent’s] safety and well-being.”

The Commission has identified several problems with this system of transportation. First and foremost is the overriding “criminalization” of the mental health treatment process. A respondent is placed in the custody of a deputy sheriff, who transports the respondent in the back of a police cruiser, often wearing handcuffs. Most consumers and family members view this process as demeaning and counterproductive to the treatment of mental illness.

The Commission also believes that significant cost and liability concerns exist with the current transportation system. No comprehensive study has yet been performed regarding the cost of using sheriffs to transport respondents. However, anecdotal evidence suggests significant costs are incurred by county commissions in transporting a respondent to the regional mental health facility or state hospital; securing the respondent at the facility pending final commitment; transporting the respondent from the facility back to the county for any hearings; and in securing the respondent at the courthouse or hearing location. The possibility of harm to respondents and others, and thereby, the increased possibility of liability to sheriffs, is increased when the respondent is transported from a mental health facility to a less secure hearing facility located in the respondent’s home county.

The cost to counties in terms of salaries and overtime for deputy sheriffs and in wear and tear on vehicles is also high.

The Commission has identified one sheriff’s office, in Jefferson County, that avoided overtime costs by hiring part-time, hourly employees to transport respondents (as well as juveniles and low-risk prisoners). These part-time employees are deputized and trained, and provided with a police cruiser with a secure “cage” -- thereby allowing the respondent to ride without handcuffs while still protecting the driver from harm.

Current West Virginia law focuses solely upon the transportation of persons entering the involuntary treatment system. No consideration is given to the transportation of persons released from involuntary treatment. The Commission heard testimony that some individuals upon release from an involuntary commitment are left to find their own means of transportation home.

2.1 The **LEGISLATURE** should amend existing statutes that provide sheriffs and county commissions with the authority to contract with other individuals, such as an ambulance service, for the transport of patients in the involuntary commitment system. The statute should be amended to place two requirements on those other individuals: they must be trained and equipped to deal with persons with mental illness, and have sufficient proof of liability insurance to address any liability to respondents or others. The statute should make clear that, by entering into an agreement, the sheriff is relieved of any responsibility for the care and custody of respondents. *See Recommendation 10.3*

2.2 Each **COUNTY COMMISSION** should encourage its sheriff’s department to explore hiring part-time county employees on an hourly basis to perform

transportation services. These part-time county employees should be deputized, appropriately trained, and sufficiently skilled to work with persons with mental illness. These employees should also be trained to evaluate the need for restraints.

- 2.3** The **LEGISLATURE** should confer upon the Department of Health and Human Resources the power to require state and regional mental health centers or Department-designated providers to assist patients released from treatment in arranging transportation to their home county. The reasonable cost of such transportation should be borne by the county commission.

ISSUE 3: ADVANCE DIRECTIVES AND SURROGATE DECISION MAKING

When a patient is competent to make health care decisions, it is undisputed that the patient should be allowed to make his or her own decisions about treatment. The West Virginia Legislature has specifically recognized that a competent patient may draft his or her own health care “advance directives,” specifying the types of treatment acceptable to the patient, and/or designating a person to act as a medical decision-maker, also referred to as a “proxy,” on the patient’s behalf.

Although West Virginia law provides for the use of patient-created advance directives for medical treatment, the current statutes do not explicitly authorize such directives for mental illness treatment. The West Virginia Department of Health and Human Resources, in conjunction with consumer advocates, has attempted to create guidelines for mental health consumers to draft advance directives that comply with the statutes. See “*Behavioral Health Consumer Rights*,” 64

C.S.R. 74.5. The Mental Health Consumer Association, in conjunction with the Department of Health and Human Resources, is also working in community mental health centers to educate consumers and their families about advance directives.

Many states have adopted legislation that specifically authorizes and sets the general terms of specialized advance care directives for mental health care. The Commission therefore recommends:

- 3.1** The **LEGISLATURE** should adopt separate legislation authorizing mental health care advance directives, in accord with the practice in other states. To clarify the validity of advance directives by persons with mental illness, a statute creating and defining a mental health care advance directive should be separate and apart from advance

directives statutes for other illnesses.

the opinion of the examining physician or licensed psychologist.

- Any statute concerning advance directives for mental health care should state that an advance directive becomes effective, and should be considered as an expression of the person's wishes as though they were competent, when it appears to a treating or examining physician or licensed psychologist or mental health decision maker that the person, because of their mental illness or for other reasons, is not competent to exercise reasonable judgment as to treatment decisions. Alternatively, an advance directive should become effective upon the filing of an "emergency certification" by a physician or licensed psychologist.
- An advance directive for mental health care should allow an individual with a mental illness to make a declaration of preferences or instructions regarding their preferred course of treatment, and specify conditions under which they should be involuntarily hospitalized or otherwise treated, including the designation of a person who would make such a decision in their best interest.

3.2 The **LEGISLATURE** should use the medical power of attorney form and standards in *W.Va. Code*, §16-30A-17 as the general format in drafting an advance directive for the treatment of mental illness.

3.3 The **LEGISLATURE** should provide that a competent individual is allowed to revoke an advance directive for mental health care at any time. An advance directive for mental health care should have no effect if the person with a mental illness is competent to make decisions, in

ISSUE 4: **REQUIRING OTHER FORMS OF TREATMENT AND MEDICATION COMPLIANCE IN AND OUT OF HOSPITALS**

How can such degradation and death -- so much inhumanity -- be justified in the name of civil liberties? It cannot. The opposition to involuntary committal and treatment betrays profound misunderstanding of the principle of civil liberties. Medication can free victims from their illness -- free them from the Bastille of their psychosis -- and restore their dignity, their free will and the meaningful exercise of their liberties.

-- Herschel Hardin, "Uncivil Liberties: Far from Respecting Civil Liberties, Legal Obstacles To Treating the Mentally Ill Limit or Destroy the Liberty of the Person," *The Vancouver Sun*, Thursday, July 22, 1993 (Mr. Hardin is the parent of an adult child with schizophrenia).

The common law sets a high value on consent to physical invasions that threaten the health or psychic integrity of the individual. The law rightly recognizes that the body is his fortress. Nevertheless, the inviolability of the body is not absolute.

-- Louis L. Jaffe

Some of the patients in the mental health system are characterized as "revolving door" patients -- individuals living a constant cycle of involuntary commitment for treatment, stabilization, and release, followed by relapse and re-commitment for failing to continue with necessary treatment. Repeated commitments for treatment are due in part to inadequate formal and informal supports and treatment, including medication.

According to the Treatment Advocacy Center, patients with psychiatric disorders refuse medication for a variety of reasons, including experience with, or fear of, side effects. In other cases the refusal is based on lack of awareness of illness or on delusional beliefs. Some patients have an awareness of their illness, but that

awareness can wax and wane. A recent study by the Treatment Advocacy Center suggests that as many as half of those individuals with *schizophrenia or bipolar disorder*⁸ have acutely impaired self-awareness of their illness. Many

⁸It is estimated that between 25,108 and 55,597 West Virginia citizens have a bipolar or schizophrenic disorder. Estimates of the prevalence for Bipolar I Disorder range between 0.4% and 1.6% of the population; for Bipolar II Disorder, 0.5% of the population; and for Schizophrenia and other psychotic disorders, between 0.5% and 1% of the population. See American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (4th Edition, 1994) at pp. 282, 353 and 360. According to U.S. census figures, West Virginia had a 1990 population of 1,793,477.

such patients must ultimately be medicated involuntarily.

Most serious mental illnesses are long-term, with periods of exacerbation and periods of remission. There are very few cases of complete remission. According to the Treatment Advocacy Center, the longer individuals with serious mental illness go untreated, the more uncertain their prospects for long-term recovery. Recent studies have suggested that early treatment may lead to better outcomes, while delaying treatment leads to worse outcomes.

When a patient is involuntarily committed to a State-run mental health treatment facility, State regulations allow the facility, as a “last resort,” to involuntarily administer necessary medications.⁹ Private mental health treatment facilities are not governed by these state regulations, and therefore are powerless to compel involuntarily committed patients to take necessary medications.

Furthermore, as addressed in Issue 1, West Virginia uses a “serious harm” standard before a person may be involuntarily treated for a mental illness. The practical application of this standard is troubling because persons with mental illness must spiral to the depths of their illness before they can be compelled to accept treatment. The result is a gradual decompensation of the person’s condition that may result in permanent damage.

To address this problem, approximately forty states use a form of “conditional” or outpatient commitment to compel patients to take necessary medications to prevent the “revolving door” syndrome. These orders allow patients to avoid or be released from involuntary hospitalization on certain conditions, namely that

⁹For the procedure used in State-operated behavioral health facilities to administer treatment and medication when the patient refuses treatment, see *W. Va. Code of Regulations*, 64 C.S.R. 59.8.5.

they continue to take their medications. If the patient fails to take required medications, a court has the authority to re-commit the patient to the hospital for additional treatment.

West Virginia currently has a statute that allows a limited form of conditional commitment. *W. Va. Code*, §27-7-2 [1975] allows mental health facilities, both public and private, to release patients from involuntary hospitalization on a “convalescent status (trial visit)” when the facility believes that such a release is in the best interest of the patient. The patient may be released to continue outpatient treatment at any mental health treatment facility.

During the six months that a patient is on “convalescent status,” the mental health facility may seek to readmit the patient. Before the patient may be readmitted, however, a circuit court or mental hygiene commissioner must be “satisfied that the condition of the patient warrants his return.”

The Commission believes that involuntary treatment alternatives should be flexible, and should be structured to allow the patient’s treating physicians to encourage compliance with prescribed medical treatments. Accordingly, conditional release should be available for patients willing at the outset to take their medication, and should be available to allow the treatment facility to release a patient to a less-restrictive environment, but easily return the patient to a hospital environment when medication noncompliance is discovered and when sufficient and appropriate aftercare is available.

The Commission therefore recommends:

- 4.1** The **LEGISLATURE** should statutorily authorize the Department of Health and Human Resources to enact regulations setting forth a procedure whereby private mental health facilities may, in a fashion similar to that used in state facilities,

administer medications or other forms of treatment to an involuntarily committed patient, when the patient rejects any proposed treatment and all attempts at negotiating an acceptable alternative have failed.

- 4.2** The **DEPARTMENT OF HEALTH AND HUMAN RESOURCES** should specify, in any regulations regarding the involuntary administration of medications or other forms of treatment to patients who reject treatment, that a patient advocate or member of the mental health treatment facility's ethics committee consult with the patient before initiating the involuntary administration of a medication or a treatment.

Commentary: The Commission recognizes that some persons with mental illness are resistant to taking anti-psychotic medications for different reasons including, but not limited to: negative side effects, inadequate understanding of the benefits and potential consequences of taking the medication, rejection of authority by younger patients, and a lack of post-discharge follow-through by health and mental health care professionals. There are, however, some limited circumstances which would warrant overriding an individual's wishes not to take medication. One such circumstance would be when someone in crisis will not agree to any form of treatment.

Any regulations should require the treating physician to use the least restrictive, least invasive form of treatment. Furthermore, any regulations must require the treating physician to take into account religious or societal objections, or other similar concerns.

A patient should be allowed to consult with a patient advocate or member of the facility's ethics committee to address the patient's questions and concerns, and to assist the patient in voicing any objections to a particular medication or course of treatment.

However, the regulations should not be so broad as to require a consultation with an advocate or ethics committee member every time the patient takes the medication, or is administered treatment.

- 4.3** The **LEGISLATURE** should amend *W. Va. Code*, 27-7-2 to ensure that:

- a.** A treatment facility may not transfer the patient to a more restrictive form of treatment unless, upon a hearing, it is found by a circuit judge or mental health officer to be necessary and appropriate.

At the hearing, the patient should be represented by counsel. Ideally, that counsel would be the same attorney that represented the patient at the commitment hearing.

- b.** If a patient is conditionally released after a commitment hearing, a process of formal review of the patient's progress should be established that involves the patient and the patient's treating physician and treatment team. Such a review should be conducted at least every 90 days, to ensure the patient is complying with conditions established in the commitment process, to determine if a less restrictive alternative course of treatment can be adopted, and to ensure that the affected mental health treatment facility is providing the necessary medications and treatment.

Commentary: Vesting complete discretion with the mental treatment facility over the level of restrictions placed on the patient does not

comport with notions of due process. Under the above approach, the mental health treatment facility may, at its discretion, lower the level of restrictions placed on the patient without holding a hearing -- hence, it may release a patient on the condition that the patient continues to take his or her medications or comply with other courses of treatment. If the patient violates that condition, the facility must notify the circuit judge or mental health officer that it wishes to re-hospitalize the patient.

A process of review, similar to a review by a multi-disciplinary team in cases of abuse and neglect of children, should be established to mandate an examination of whether the patient is complying with the prescribed treatment, and whether the hospital is actually providing necessary services. This hearing allows treating physicians and the patient to work together to develop the least restrictive, most effective form of treatment -- while also compelling the patient to comply with a course of treatment and to take necessary medications.

Before a patient can be conditionally committed, the mental health officer must determine if the appropriate services and resources exist to provide the patient with the necessary treatment outside of the hospitalization environment.

II. SERVICES

Issue 5: Use of, and Incentives for, Crisis Services, Preventive Services and Aftercare

Issue 6: Adequacy of Commitment Procedures For, and Placement Of, the Forensic Population

Issue 7: Treatment and Placement Issues for Substance Abusers

Issue 8: Treatment and Placement of Children in the Involuntary Commitment System

While much of the focus of the Commission on Mental Hygiene Reform, was in the area of practices, policies, procedures and statutes as they relate to involuntary commitments, we have taken a slightly broader look at the area of services. We have done so with the clear understanding that the existence and array of available services have a direct impact on the commitment system. That is, the more successful and available the preventive and aftercare services, the fewer number of involuntary commitments we should have in West Virginia.

ISSUE 5: USE OF, AND INCENTIVES FOR, CRISIS SERVICES, PREVENTIVE SERVICES AND AFTERCARE

A recent study by the National Association of State Mental Health Program Directors' Research Institute, Inc.¹⁰ found that, on a *per capita* basis, West Virginia ranks fiftieth out of fifty-one in State agency spending on mental health. We spend an average of \$23.02 *per capita* as compared to the national average of \$64.31 *per capita* on mental health services. While, the Commission does not believe that the amount of money expended is the sole criterion of success, we do believe that these numbers demonstrate that there is a great need for additional resources -- public and private -- in the area of mental health.

5.1 A REFORMED INVOLUNTARY COMMITMENT SYSTEM must consist of

a continuum of accessible transitional services -- from preventive services in the community through crisis intervention to after and long-term care. **FAMILY MEMBERS** and **PEER COUNSELORS** should be included in a services plan, where appropriate. The goal of the current system in West Virginia is consistent with this outcome -- the gaps in the current system which cause it to fall short.

There are many areas where it is important that the State and the private sector be encouraged to partner for problem solving and funding. We strongly believe that while the State must improve on the funding of necessary services, the burden must not fall solely on taxpayers. By partnering with the private and nonprofit sectors, the State can leverage its funds

¹⁰Report entitled "Funding Sources and Expenditures of State Mental Health Agencies Fiscal Year 1997," Final Report, July 1999.

and bring important insights into the provision of mental health services.

In other states, publicly-funded service providers have partnered with nonprofit agencies and volunteers to provide services for consumers. For example, in Tennessee, volunteer peer counselors work with consumers in crisis in a private setting to avoid involuntary hospitalizations. These types of partnerships provide services without additional public cost, and should be aggressively pursued in West Virginia.

5.2 SERVICE PROVIDERS should partner with **NONPROFIT AGENCIES** and **VOLUNTEERS** to provide necessary community-based treatment services.

A. Expanding Access to Services

A recent study prepared for the National Association of Psychiatric Health Systems, the Association of Behavioral Group Practices, and the National Alliance for the Mentally Ill found that the total value of behavioral health care provided by employers in this country dropped by 54.1% (comparing 1988 to 1997) and that in 1997, 57% of employer plans imposed a day limit (the most prevalent being a 30-day limit) on inpatient care (compared to 38% in 1988), and 48% imposed annual visit limitations for outpatient visits (compared to 25% in 1988).

In response to this issue, a growing number of states have enacted some form of “parity” legislation. While varying in wording from state to state, the fundamental concept behind parity legislation is to reverse the trend of decreasing insurance coverage for behavioral health care. The legislation, therefore, provides that every health care insurer -- public and private -- will provide for coverage of mental or behavioral illness “under the same terms and conditions as coverage is provided for other illnesses or diseases.”

While we will not endorse specific legislation, we do believe that it is important that any parity legislation include both public and private insurance and include a broad definition of mental illness that includes substance abuse and is consistent with other provisions of State law, *i.e.*, serious emotional disturbance.

To supply the services necessary to treat West Virginians with mental illness, it will be necessary to bring more money into the system. Many states have found that parity legislation saves money by bringing private dollars into a primarily publicly funded health system. In fact, more than twenty states now have some degree of mental health parity and twelve more states have parity legislation pending.

5.3 The **LEGISLATURE** should adopt broad parity legislation to ensure public and private insurance coverage of mental and behavioral illnesses.

B. Community-Based Care

In calling for the creation of a Commission on Mental Hygiene Reform, the Commission on the Future of the West Virginia Judiciary called on the State to expand “mobile, face-to-face, crisis intervention services” as well as increase funding to enable the State’s fourteen regional mental health centers to become “more active in crises intervention.” We reaffirm the importance of these statements. Crisis intervention and preventive services -- based in the community -- will serve consumers, their families and the State as a whole.

West Virginia should set as a goal the creation of a continuum of accessible services -- from preventive services in the community through crisis intervention to after and long-term care. These services must include, where appropriate:

- Collaborative relationships with community hospitals to provide acute patient psychiatric care;

- Locally/regionally-based peer counseling, intervention and advocacy;
- Respite and long-term care;
- Locally/regionally-based alternative housing arrangements;
- Inclusion of families in crisis intervention and aftercare;
- Expanded use and availability of mobile crisis capacity.

5.4 The **LEGISLATURE** should support, and **OFFICE OF BEHAVIORAL HEALTH SERVICES** and **TREATMENT PROVIDERS** should adopt, empirically-based treatment programs, such as “assertive community-based treatment programs,” for the treatment of individuals with severe mental illness.¹¹

¹¹We have reviewed the growing use of model community-based programs for the critically mentally ill that include many of these elements. One such successful community-based model, developed in Wisconsin, is entitled the Program for Assertive Community Treatment (PACT). The PACT model is a multi-disciplinary, mental health staff organized as an accountable, mobile mental health agency or group of treaters who function interchangeably to provide treatment, rehabilitation, and support services that persons with severe mental illness need to live successfully in the community.

The Office of Behavioral Health Services reports that PACT programs have been implemented at Pretera Center in Huntington, Health Ways in Weirton, and Valley Health Care in Morgantown. The Office of Behavioral Health Services reports a reduction in State hospital utilization including length of stay and hospital admissions and states, “[t]he outcomes produced by the three PACT teams have demonstrated the effectiveness of providing this service to persons who have serious mental illness, but who also have high hospital utilization and recidivism rates.”

We know that the State is interested in PACT,
(continued...)

Mobile crisis units have worked in West Virginia. For example, East Ridge Health Systems of Martinsburg reports that from April 1, 1998 through March 31, 1999, its mobile crisis team diverted 288 commitments and facilitated 98 commitments saving the mental hygiene system “at least \$233,280 without including the hospital bed time that may have occurred.”¹²

Despite the success of the program at East Ridge and other similar mobile crisis team programs, and the fact that the existing contract between the State and the community mental health centers’ mandate crisis intervention systems, the funding for these units has been a patchwork of federal grant and seed monies that all too quickly end.

5.5 The **LEGISLATURE** should locate and provide a replicable and expansive funding source for the duplication of mobile crisis capacity throughout West Virginia.

Community mental health centers struggle to fund necessary services that are not reimbursed by Medicaid. The funding of mobile crisis teams is one such example. The community mental health centers tend to establish service programs under grant funding, and when those grants inevitably dry up, community mental health centers must suspend services that may be very effective and that

¹¹(...continued)

and that it and similar programs have been implemented with success in certain areas throughout West Virginia. We also recognize the differences between rural and urban areas and the special issues that these differences have on the implementation of a PACT-type program. PACT has been successfully implemented in both rural and urban settings and has been funded by Medicaid reimbursement.

¹²These savings are attributable to savings in procedural costs, *i.e.*, savings in court, representation, and transportation costs.

consumers have come to rely upon. To avoid these problems, community mental health centers should consider contracting for service provision with outside providers as opposed to attempting to provide comprehensive services in-house.

5.6 The **COMMUNITY MENTAL HEALTH CENTERS** should, when appropriate and feasible, contract for the provision of needed services with outside providers.

ISSUE 6: ADEQUACY OF COMMITMENT PROCEDURES FOR, AND PLACEMENT OF, THE FORENSIC POPULATION

A. The Forensic Population

The forensic population is made up of those criminal defendants found incompetent to stand trial, or “not guilty by reason of insanity.” Unlike the nonforensic population whose average hospital stay has been dramatically reduced in recent years, forensic patients remain hospitalized for lengthy periods. According to the Department of Health and Human Resources, as of August 12, 1999, 44% (about 22 individuals) of the forensic patients at Sharpe Hospital had a current length of stay of greater than one year. For other patients, that is, excluding those under court order, only 12.5% had a current length of stay of greater than one year.

One issue that will be facing the State in the coming years is the question of whether to establish a separate secure forensic program. At present, Sharpe Hospital has a forensic population of approximately forty. This population is expected to continue to grow in the coming years.

6.1 The **LEGISLATURE** should plan for the establishment of sufficient forensic services that will not compromise acute care services for persons with mental illness and that will allow forensic patients to be housed separately from other patients.

6.2 The **DEPARTMENT OF HEALTH AND HUMAN RESOURCES** should develop more community-based placements for the forensic population.

Since 1995, West Virginia has provided that defendants can be found “not guilty by reason of insanity.” These individuals are placed under the jurisdiction of the court for the duration of the maximum sentence for the crime charged.

The court then places the individual in a facility under the jurisdiction of the Department of Health and Human Resources, not the Division of Corrections. The Department of Health and Human Resources should report to the court with status updates and any proposals for changes in placement. Placement and treatment of many forensic patients are not reviewed by the courts on a regular basis.

In order to ensure that forensic patients are afforded reasonable review of their commitment, the State should look to the review system currently in place for children in West Virginia who are wards of the State. Such a system would maintain court jurisdiction throughout the commitment and would require the court to review a commitment at least once every six months.

6.3 The **LEGISLATURE** should enact legislation that retains court jurisdiction over long-term commitments and mandates automatic periodic court review. That legislation should include the following elements:

- Counsel for defendants (including appointed counsel and public defenders) remain counsel until the jurisdiction of the court is concluded;
- Hospitals are included in all proceedings and are entitled to notice and an opportunity to be heard;
- The court of original jurisdiction holds review hearings every six months for as long as the court retains jurisdiction;
- A discharge plan is developed by the community mental health facility in

conjunction with counsel for the defendant, present and prospective service providers, and the prosecuting attorney or appropriate counterpart in a reformed system;

- The discharge plan is presented to the court which could amend or reject it only with specific findings as to grounds;
- Both the defendant and the State would have the right to appeal the discharge plan.

The need for family involvement in the treatment of patients was a consistent theme throughout the Commission's work. Family involvement is equally important in the treatment of forensic patients. There are, however, many instances where it is impractical for family members to be physically present. The involvement of family members through the use of video conferencing technology could be an important substitute.

6.4 TREATMENT PROVIDERS, whenever possible, should include family members in the treatment of forensic patients and investigate the purchase and use of video conferencing technology for the inclusion of family members in treatment where appropriate. This could be accomplished through electronically linking the community mental health centers with the state hospitals.

B. West Virginia's Prison and Jail Populations

A recent study by the United States Department of Justice confirms what many in the mental health community have known to be true -- that a sizable portion of the inmate population

in this country has severe mental illness. The recently released study found that about 16% of this nation's prison population has severe mental illness and these inmates spend an average of fifteen months longer in prison as a result of their behavior. Inmates with severe mental illness who do not receive adequate treatment continue to be a danger to themselves and potentially, to those around them.

Likewise, the ties between substance abuse and crime are long documented. One way to break the link in the chain of recidivism is through treatment and rehabilitation. Department of Public Safety Secretary Otis Cox recently stated that the number of prisoners being held for drug and alcohol related crimes and the number of inmates with substance abuse problems is growing, "It's the fastest growing population throughout the country." According to Secretary Cox, in West Virginia, correction- related substance abuse programs are found only at the Pruntytown Correctional Center in Taylor County and a work-release program for drunk-drivers in Beckley.¹³ Currently, the Department of Health and Human Resources and the Regional Jail Authority are working to establish a treatment center at the site of the old Eastern Regional Jail in order to demonstrate the effectiveness of substance abuse treatment.

6.5 The DEPARTMENT OF HEALTH AND HUMAN RESOURCES, in conjunction with the **DIVISION OF CORRECTIONS** and the **REGIONAL JAIL AUTHORITY**, should implement a system of diagnosis and treatment for mental illness/substance abuse in the jails and prisons throughout the State.

¹³Charleston Daily Mail, September 9, 1999.

ISSUE 7: TREATMENT AND PLACEMENT ISSUES FOR SUBSTANCE ABUSERS

The role of substance abuse as it relates to mental health is of critical concern to the mental health community. The Commission's survey of that community found that 55% of respondents ranked the placement and treatment of substance abusers in the top three most significant issues facing the involuntary commitment system in West Virginia. The number of substance abuse-related admissions to the state hospitals bears out this concern. As an example, in fiscal year 1996-1997 and again in fiscal year 1997-1998 fully 20% of the admissions at Bateman Hospital were for addiction.

In terms of dual diagnosis, the numbers are even greater. While exact numbers are difficult to determine, the Office of Behavioral Health Services reported that nearly 30% of the patients at Sharpe and Bateman Hospitals have dual diagnoses of substance abuse and mental illness and/or mental retardation.

The treatment of individuals with substance abuse problems is a state responsibility and must be recognized as such. In the same manner that the State provides a continuum of care for others with mental health needs, treatment should be provided for those with substance abuse as well.

Recent changes in federal social security disability law to eliminate coverage for substance abuse have placed a financial burden on the State. This federal policy fails to consider the impact -- financial and human -- that the lack of treatment and support can have on a community. It is a policy that should be reviewed.

7.1 Due to the very limited amount of services in West Virginia for substance abuse treatment, the **LEGISLATURE** should focus on providing the following services:

- Allowing for a sufficient period of time for medical detoxification, in an appropriate secured facility or a sufficiently supervised facility with restraints (taking into consideration the patient's physical complications that accompanies withdrawal);
- The creation of additional detoxification and long-term treatment services that include the community mental health centers and private entities;
- Expanding screening and services in the regional jails and prisons;
- Expanding cooperation with the private sector and encouraging the creation and use of an employer provided Employee Assistance Programs at the workplace; *and*
- The expansion of community-based halfway house facilities.

7.2 The **STATEWIDE COMMISSION** should further study substance abuse problems in West Virginia's senior and minority populations. (*See Recommendation 9.1*).

ISSUE 8: TREATMENT AND PLACEMENT OF CHILDREN IN THE INVOLUNTARY COMMITMENT SYSTEM

A. Relinquishment of Custody to Obtain Treatment Services

Some people, in order to obtain insurance coverage for mental health services, have been forced into drastic actions -- including abandoning a family member or relinquishing custody of a child. Too often, due to the inadequate coverage of mental health treatment in private insurance plans, these drastic actions were taken to ensure Medicaid coverage for the consumer.

According to a new study by the Center for Mental Health Services and the Bazelon Center for Mental Health, the cause of the need to relinquish custody of one's child in order to obtain coverage is the lack of a comprehensive system for children's health care and the shift away from mental health coverage in public and private health insurance. According to the Bazelon Study, eleven states have enacted specific legislation to prevent this practice. Unfortunately, West Virginia has been identified as one of six states with the highest reported incidence of child custody relinquishment in order to obtain mental health services. To remedy this tragic situation, the Commission endorses the Final Recommendations of the Bazelon Report.

No parent should be forced to relinquish custody of a child in order to obtain mental health services for that child.

8.1 The **LEGISLATURE** is urged to review the actions of other states and to enact legislation to prevent the relinquishment of custody in order to obtain mental health services.

Particularly:

- The **LEGISLATURE** should enact legislation which prohibits the child welfare system from requiring custody relinquishment or transfer as a condition for receiving mental health services and allowing for "voluntary placement and care" agreements without the necessity of a custody transfer. Such legislation should also require court oversight and review of any "voluntary placement and care" agreements extending ninety days or longer. (See Oregon statute ORS 418.312).
- The **LEGISLATURE** should enact legislation granting a circuit court jurisdiction to order mental health services on behalf of children who require treatment services their parents cannot financially provide, when these services are necessary to prevent custody transfer or relinquishment solely for financial reasons. The court should be granted jurisdiction over both mental health service providers and child welfare agencies. (See statutes of Iowa and Minnesota).
- The **LEGISLATURE** should consider enactment of a Comprehensive Services Act for At-Risk Youth. (See statutes of Virginia).

To assist in payment, we believe that this is another area we should look to private and public insurers. The West Virginia Legislature should require insurance payment for necessary hospitalization or community-based treatment for children and dependents in specific situations where insurance has reached a cap on payments or where the parents have no health insurance. West Virginia can avoid making children wards of the State simply because of the lack of financial resources. If such proposed legislation

is enacted in conjunction with parity legislation, and limited to children or other dependants, the number of cases falling within these provisions will be small. We also believe, however, that in situations where the provisions are applicable, the child, the parents and the State will benefit.

8.2 The **LEGISLATURE** should adopt a State and private/public insurer partnership for payment for necessary hospitalization or appropriate community-based treatment when it is necessary to avoid commitment, for nonstate wards without sufficient financial resources.

This legislation should include the following elements:

- A mechanism by which it is determined that the patient (or patient's legal guardian) is unable to obtain necessary mental health services because of the lack of insurance, or if insurance exists, because the insurance payment cap has been met or other mental health services exclusions apply.
- A review of treatment needs should then be undertaken by an independent Mental Health Care Services Review Panel, consisting of at least a psychiatrist, a psychologist and other appropriate representatives of mental health professionals and the community.
- A treatment plan should be developed by the Panel, the patient if possible, and other interested parties, such as family and community support members. In cases where (a) hospitalization or residential treatment is required, or (b) where community-based services are necessary to prevent hospitalization, or (c) residential treatment is required, or (d) where community-

based services are necessary to prevent hospitalization/residential treatment, then the plan, with these services included, should be reviewed at a hearing conducted by the Panel. The Department of Health and Human Resources and any insurance carriers potentially liable for payment should be notified of the hearing and should be allowed to participate. Should the Panel find the services to be necessary, the services will be "court-ordered." The necessity of the "court-ordered" services should be reviewed by the Panel every ninety days.

- As a condition of issuing health insurance in West Virginia, all private and public insurance carriers should be required to pay for these necessary "court-ordered" treatment services, regardless of mental health services caps or exclusions. If the patient has no insurance or the carrier has refused to pay, the State should be required to pay, with the right to seek reimbursement from the appropriate carrier, if any.

8.3 To further minimize unnecessary child custody transfers or relinquishments in order to obtain mental health services, the **DEPARTMENT OF HEALTH AND HUMAN RESOURCES** should pursue mechanisms to expand eligibility for Medicaid, including (1) application for a "home and community-based" waiver for children with serious emotional disturbances, and (2) adopt or enforce an option to cover children with severe disabilities, known as the "Katie Beckett" option, to expand coverage to children with severe conditions who would otherwise obtain coverage only if they were institutionalized.

B. Placement and Treatment

Throughout the Commission's deliberations, we heard from individuals involved with West Virginia's mental health system as well as from members of the public that there are an insufficient number of beds for the long-term treatment of children and adolescents in West Virginia.

Facilities for the long-term treatment of children in West Virginia are limited. There are four facilities in West Virginia, with a total of 126 beds, that will accept involuntary commitment of children. Of these 126 beds, only 90 are for mental health care or addiction treatment.

8.4 The **LEGISLATURE**, in conjunction with the **DEPARTMENT OF HEALTH AND HUMAN RESOURCES**, should work toward increasing the number of beds for the long-term treatment of children and adolescents in West Virginia.

C. School Involvement

There is much recent concern and effort being brought to the issue of safety, schools and our children. The recommendations are focused on those children in our society who need and deserve services for mental health problems. The adoption of these recommendations should assist -- through early intervention in the lives of these children -- in the prevention of more serious efforts including commitments.

8.5 **WEST VIRGINIA'S SCHOOLS** should have an increased involvement in mental health screening and counseling, and should play an important role in early intervention.

- **CERTIFIED GUIDANCE COUNSELORS** should be required to be available at all grade levels.

- The **STATE** and **LOCAL BOARDS OF EDUCATION** should adopt a policy of mandated referral of children suspended for disruptive behavior to community mental health centers for screening and services.
- **SCHOOL COUNSELORS** and the **Community Mental Health Centers** should strive for increased communications as a means of getting increased services to children, and to coordinate care during the summer months.
- **COUNSELORS** should be relieved of administrative duties to free them up to provide needed counseling services

8.6 The placement and treatment of children involved in the involuntary commitment system are areas for increased public/community/private collaboration, therefore the Commission encourages the **DEPARTMENT OF HEALTH AND HUMAN RESOURCES** to reach out to all sectors for their resources, ideas and assistance.

D. Screening Services

As the data on the overall prison system in the country and the number of inmates with mental illness included in the prison population tells us, the criminal justice system has too often become a substitute mental health program. With regard to juveniles, the situation is much the same. The juvenile delinquency system and the abuse and neglect system too often operates as inadequate substitutes for mental health services. Presently, the State of West Virginia has no working system to perform mental health screening for this population and fails to provide sufficient mental health services. It is important that we ensure that the State does not, through inaction, criminalize mental illness.

We understand that the level and type of services provided to juveniles will depend on the results of the screening. That is, some individuals may require extensive assistance and may need to be removed from the criminal justice system, while other individuals (likely the overwhelming majority) will need active intervention that is designed to change behavior, without minimizing or curtailing the consequences of the actions which brought them to the delinquency system.

8.7 The DEPARTMENT OF HEALTH AND HUMAN RESOURCES and the DIVISION OF JUVENILE SERVICES should establish a mental health screening and services program for individuals in civil abuse and neglect cases (including both children and respondents) and those entering the juvenile justice system.

With appreciation for the potential burden that a mental health screening requirement could have on the juvenile justice system, that screening should be mandatory in cases where: (a) the juvenile encounters the system to the extent of the “work out” phase a second time, (b) the case has reached the adjudicatory level, or (c) out-of-home placement is being considered.

III. ACCOUNTABILITY, OVERSIGHT AND EDUCATION

Issue 9: Uniformity and Accountability of Service Providers, the Courts, and State Agencies

Issue 10: Provider Liability and Law Enforcement Liability Issues

Issue 11: Public Awareness and Consumer Education

Issue 12: Sufficiency of Training for Judicial Officers, Attorneys, and Law Enforcement

Issue 13: Integration and Coordination of Technology in the Involuntary Commitment System

ISSUE 9: UNIFORMITY AND ACCOUNTABILITY OF SERVICE PROVIDERS, THE COURTS, AND STATE AGENCIES

Statewide, there are substantial deficiencies in the uniformity, accountability, coordination, collaboration, feedback, and oversight of the agencies and stakeholders involved in the current involuntary commitment system.¹⁴

In short, the broad arrays of agencies, groups, and individuals that comprise the present system are working in good faith -- but they are not “working together” as they should to perform their various roles and duties, evaluate their efforts, and to plan and implement improvements.

As a society, we must and will continue to change and improve our response to mental illness. A modern mental health system must have at its core a powerful institutionalized ability to continuously evaluate, change, and improve itself.

If mechanisms are put in place to institutionalize a process of meaningful and collaborative self-evaluation, planning, and ongoing self-improvement, our State’s involuntary commitment system can continue to effectively change, and be humane, efficient, and effective for many future generations of West Virginians.

9.1 The SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN RESOURCES

¹⁴ The Commission found lack of uniformity in the following areas: the initial preparation of applications; transportation and detention proceedings and standards; probable cause proceedings’ standards and procedures; legal representation standards and practices; advocacy services; post-hospital release services; crisis response procedures and services; and data collection and reporting. Accountability, planning, coordination and oversight deficits are found regionally and statewide in the areas of: data collection, analysis, and reporting; goal-setting; research; feedback; evaluation; communication; collaboration; and advocacy.

and the **CHIEF JUSTICE OF THE SUPREME COURT** should establish a *Statewide* commission to lead an ongoing process of cooperation, evaluation, assessment, and planning for continuing improvement of the involuntary commitment system on a statewide basis.¹⁵

Additionally, ongoing oversight and direction of *regional* participants by the statewide agencies that have an oversight role over those participants is necessary to keep the system looking at itself and improving over time.

The two key statewide agencies with oversight duties are the Department of Health and Human Resources, through its subsidiary agency, the Office of Behavioral Health Services and the Supreme Court of Appeals of West Virginia. The Office of Behavioral Services has the primary responsibility for clinical and treatment issues. The Supreme Court is currently assigned the role

¹⁵ The Commission should be comprised of about fourteen persons. Suggested membership: a private attorney experienced in representing people with mental illnesses; the Secretary of the Department of Health and Human Services or his or her representative; a director of a community mental health center; an administrator from a state psychiatric facility; a consumer of mental health services; a family member of a consumer of mental health services; a family member of a minor child with a mental illness; a mental health officer (the judicial decision maker in involuntary commitment matters); a prosecutor or appropriate counterpart in the reformed system; a sheriff; a county commissioner; a member of the Senate; a member of the House of Delegates; a psychiatrist with experience in the involuntary commitment system; representatives from the Division of Corrections and the Regional Jail Authority with responsibility in the supervision of inmates who have mental illnesses; a representative of the Supreme Court of Appeals; and the chair of the Mental Health Planning Council. The Department of Health and Human Resources and the Supreme Court should provide staffing for the Commission.

of administering procedures that respect the liberty, treatment and other rights of participants in the system.

9.2 The Office of Behavioral Health Services should substantially and significantly increase its role in oversight, monitoring, assessment, and direction of the activities of the community mental health centers and other health service providers as appropriate, as they impact on and relate to the involuntary commitment system -- including assuring the availability of appropriate crisis intervention services with emphasis on mobile crisis capacity,¹⁶ and the continuum of community-based care which reduces the need for involuntary hospitalization.

9.3 The Office of Behavioral Health Services should establish standards for the community mental health centers related to services implemented in the involuntary commitment system, and monitor compliance with those standards.

9.4 The SUPREME COURT should exercise increased supervision, oversight, and direction regarding the Court's duties in the involuntary commitment system. Judicial branch mental health decision-makers should be directly appointed by the Supreme Court, in consultation with circuit judges, and should act under the direct supervision of the Supreme Court. The Court should promulgate "Involuntary Commitment Rules of Procedure" and other needed administrative rules for improved

operation of the system, including rules regarding collection of data.

9.5 The SUPREME COURT should, by rule, establish minimum standards that attorneys must employ when representing persons in involuntary commitment proceedings.

Just as important as the need to establish *statewide* procedures for ongoing oversight, cooperation, collaboration, self-evaluation, and planning for improvement -- is the need to establish such procedures on a *regional* basis. The community mental health center service area is the logical regional "jurisdiction" for training, planning, coordination, and collaboration in the ongoing regional operation and improvement of the involuntary commitment system.

9.6 To the extent possible, the SUPREME COURT should make the **COMMUNITY MENTAL HEALTH CENTERS' SERVICE AREAS** should serve as a region or jurisdiction for all data collection, planning, training, and evaluation programs associated with the involuntary commitment process. Reform of the involuntary commitment system should include placing the community mental health center, to the extent feasible, as a "gatekeeper" or single point of entry into the involuntary commitment system.

9.7 The SUPREME COURT should tie the jurisdiction of the decision-makers who make involuntary commitment determinations to the service areas of the community mental health centers, as opposed to the current practice of tying the decision-makers' jurisdiction to judicial circuit boundaries.

¹⁶ Mobile crisis teams are staffed by trained mental health workers who have the ability to go into the community and work with other providers to resolve individual mental health crises.

Commentary: The lack of congruence between the boundaries of the judicial circuits and the treatment areas of the community mental health center can lead to complications and difficulties

for the community mental health centers in implementing the system within their service areas.

9.8 THE OFFICE OF BEHAVIORAL HEALTH SERVICES should require each **COMMUNITY MENTAL HEALTH CENTER** to conduct semiannual meetings of key stakeholders and participants in the involuntary commitment process in the community mental health center's service area, to discuss the operation of the system in the service area and how it can be improved. Attendance must be mandatory for the administrator or clinical director of the state hospital system, the executive director or clinical director of the community mental health center, the head of the Office of Behavioral Health Services, and all mental health officers (involuntary commitment decision-makers) for the service area. Other key stakeholders must be invited. These include representatives from: state and private social service agencies; community/private hospitals; the prosecutor's office or appropriate counterpart in a reformed system; local law enforcement and emergency services providers; circuit clerks; attorney advocates; Supreme Court administrative staff; local school systems and school counselors; and peer, consumer, and family groups.

9.9 The **SUPREME COURT** should adjust the role of the circuit clerk to reflect the needs of a reformed system --including clear, uniform procedures for file creation and handling, and improved data collection and reporting.

ISSUE 10: PROVIDER LIABILITY AND LAW ENFORCEMENT LIABILITY

For many participants in the involuntary commitment system, liability is a key concern. Current “immunities” that apply to the involuntary commitment process, both statutory and court-made, are not models of clarity or predictability. All participants -- particularly those who do not have some form of governmental immunity -- are aware that their conduct relating to the involuntary commitment system may lead to a claim of liability for money damages.

Liability concerns may actually drive the system toward increased involuntary hospitalizations and toward “criminalization.” For example, emergency room doctors and mobile crisis workers may seek to commit a person who does not necessarily need to be committed to avoid the risk of liability. Likewise, sheriffs may transport respondents, instead of allowing alternative, less “criminal” individualized transportation, because liability remains with the sheriffs in either case.

Any changes in the involuntary hospitalization decisional process -- such as emergency certification or temporary observation procedures -- must provide for appropriate immunity for the decision-maker and persons participating in the decisional process in good faith.

10.1 The **LEGISLATURE** should carefully evaluate and structure any proposed changes in the current involuntary commitment system so as to (a) ensure that the judicial immunity that has been provided to mental hygiene commissioners be afforded, by statute, to any decision-maker with a similar role, *e.g.*, licensed psychologists; (b) eliminate the risk of liability of any other participants in the system for good-faith actions performed in conformance with system-wide standards; and (c) minimize liability concerns that may drive the

system toward increased involuntary commitment proceedings. Standards for the discharge of responsibilities must be clearly established.

10.2 The **LEGISLATURE** should amend the involuntary commitment statute to remove liability from a sheriff who agrees to alternative individual transportation with the approval of the involuntary commitment decision-maker.

Commentary: Occasionally, family members or other supportive persons volunteer to transport a respondent to a treatment facility. Some sheriffs are hesitant to allow that type of transport because the sheriff remains liable for any damages.

10.3 The **LEGISLATURE** should amend existing statutes that currently provide sheriffs and county commissions with the authority to contract with other individuals, such as an ambulance service, for the transport of respondents in the involuntary commitment system. The statute should be amended to place two requirements on those other individuals: they must be trained and equipped to deal with persons with mental illness, and have sufficient proof of liability insurance to address any liability to the respondent or others. The statute should make clear that, by entering into an agreement, the sheriff is relieved of any responsibility for the care and custody of the respondent. *See* Recommendation 2.1.

Commentary: Existing statutes allow the sheriff and county commission to enter into a contract to allow ambulance agencies and other individuals to transport persons subject to involuntary commitment proceedings. However, the existing statutes are not clear regarding whether a sheriff continues to be liable for the care of the

transportee. Because of this, sheriffs are reluctant to give up the duty of transport. A sheriff should, statutorily, be allowed to shift both custody and liability to a responsible agency if the sheriff so chooses.

10.4 To decrease liability concerns, **MENTAL HEALTH SYSTEM PARTICIPANTS** should encourage and promote the use of advance directives. Advance directives can diminish the liability concerns of physicians, psychologists, providers and other stakeholders in the system. Where appropriate, the application of advance directives should be mandatory in any judicial forum. Acting in accordance with an advance directive should be considered evidence of good faith in a liability action.

ISSUE 11: PUBLIC AWARENESS AND CONSUMER EDUCATION

The involuntary commitment system is poorly understood by, and poorly explained to, consumers, families, providers, and the public at large. Consumers and families who are involved in the involuntary commitment system are often confused and frightened, in part because they do not understand the system. Ignorance leads to fear, frustration, and confusion. Unfortunately, the current system's use of "dangerousness" as an articulated standard, perpetuates the irrational fear of people with mental illness.

Only continuous, frank, and assertive public discourse about mental illness will break down discrimination, stereotypes, and stigma. A reformed involuntary commitment system should have a substantial educational component, to explain the system to the public and to stakeholders.

11.1 The **OFFICE OF BEHAVIORAL HEALTH SERVICES** should direct and assist **COMMUNITY MENTAL HEALTH CENTERS** in assertively seeking media coverage for mental illness treatment issues -- including the involuntary commitment process -- to bring the issues involved out of the shadows.

11.2 The **OFFICE OF BEHAVIORAL HEALTH SERVICES** should compile and disseminate educational and training materials on mental illness, as well as create new materials (brochures, handbooks, audiotapes, videotapes, and reference materials) in a concerted and well-planned "marketing" campaign.

11.3 The **OFFICE OF BEHAVIORAL HEALTH SERVICES** should establish State and regional "speaker lists" of volunteers, consumers and professionals who are available to present

programs/lectures/training on a regular and continuing basis.

11.4 The **OFFICE OF BEHAVIORAL HEALTH SERVICES** should establish outreach programs to increase awareness within the community and within schools of the services available through the community mental health centers. These programs should specifically target crisis and other traditional and nontraditional emergency services which are available on a twenty-four-hour basis.

Commentary: Because stereotypes and fears begin at early ages, schools can be valuable arenas for combating ignorance about mental illness.

11.5 The **OFFICE OF BEHAVIORAL HEALTH SERVICES** should require each **COMMUNITY MENTAL HEALTH CENTER** to collaborate with, and provide some limited technical assistance to, establish independent consumer, family member, peer, and advocate groups as an integral part of the community mental health center's daily activities.

ISSUE 12: SUFFICIENCY OF TRAINING FOR INVOLUNTARY COMMITMENT SYSTEM PARTICIPANTS

Training increases knowledge and skills and results in positive attitude changes. Multi-agency, multi-disciplinary training coordinates delivery of services and operation of the system and promotes collaboration. Combining training with consultation, feedback, and planning furthers this goal even more. There must be systemic, ongoing training for all participants in the State's involuntary commitment system.

12.1 The **SUPREME COURT OF APPEALS** and the **OFFICE OF BEHAVIORAL HEALTH SERVICES** should continue to provide statewide, multi-day, multi-disciplinary, regional training seminars, *e.g.*, best practices, under a criteria and format established by the Statewide Commission (*see* Recommendation 9.1) not less than once every two years.

12.2 The **SUPREME COURT** and the **OFFICE OF BEHAVIORAL HEALTH SERVICES**, in conjunction with each **COMMUNITY MENTAL HEALTH CENTER**, and as directed by the **STATEWIDE COMMISSION**, should be required to host semiannual regional training, evaluation, and planning events, involving all participants in the involuntary commitment system in the community mental health center's service area. These meetings would be similar to the larger Statewide Commission meeting recommended in 9.8, but on a smaller scale.

- **PUBLICLY-FUNDED SERVICE PROVIDERS, ADVOCATES AND CONSUMER AND FAMILY GROUPS, and OTHER PUBLICLY-FUNDED PARTICIPANTS** in the involuntary commitment system, should be required as a condition of their

receipt of public funding to participate in these regional sessions.

- If the system is to positively change, that change ought to be driven by those who are most directly involved in the process, *i.e.*, **CONSUMERS, THEIR FAMILIES, AND ADVOCACY GROUPS**. Therefore, these persons should be involved in the organization of regional meetings.
- The **COMMUNITY MENTAL HEALTH CENTER** should use video conferencing systems, where available, at the regional meetings to bring centrally-produced presentations to regional sites.

12.3 The **SUPREME COURT** and the **DEPARTMENT OF HEALTH AND HUMAN RESOURCES** should promulgate and disseminate a comprehensive, uniform, "best practices" handbook. The Statewide Commission should coordinate production of the handbook.

12.4 The **SUPREME COURT** should collaborate with **WEST VIRGINIA CONTINUING LEGAL EDUCATION** to create a "mental health training" for attorneys who represent persons subject to involuntary commitment proceedings.

12.5 An **ATTORNEY'S** eligibility for publicly-funded appointment to represent people who are the subject of involuntary commitment petitions should be conditioned upon the attorney's annual participation in multi-disciplinary training about the system. In the absence of attorneys who have undertaken such training, the circuit court should have the discretion to appoint individual attorneys

based on their experience with involuntary commitment issues.

Commentary: Attorneys play a key role in the existing involuntary commitment system in West Virginia. In many cases, private attorneys are appointed to represent persons who are the subject of involuntary commitment proceedings. In other cases, public defenders provide representation.

ISSUE 13: INTEGRATION AND COORDINATION OF TECHNOLOGY IN THE MENTAL HEALTH SYSTEM

Judicial, social service, and medical provider systems are increasingly using state-of-the-art video conferencing to dramatically improve information sharing, training, consultation, and collaboration -- and to dramatically reduce human transportation needs. There is significant potential in the involuntary commitment system for such uses of video conferencing.

For example, Northwood Health Systems, the community mental health center that serves citizens in the State's Northern Panhandle, has recently received a grant to help it establish a video conferencing network with both Sharpe and Bateman Hospitals. Northwood will use the network to enable consumers, treatment teams, advocates and family members to collaborate in the treatment and release process.

Moreover, Internet and intranet technology is ideal for posting and distributing forms, documents, rules, regulations, memos, brochures, and laws relating to the statewide operation of an involuntary commitment system. E-mail and listservs are an excellent means of collecting data on the operation of the system, and disseminating the results of the data collection.

13.1 The **COMMUNITY MENTAL HEALTH CENTERS** and the **PSYCHIATRIC STATE HOSPITALS** should increase the use of electronic communication, including video conferencing for discharge planning and related consultation, and for secure electronic record keeping.

13.2 The **SUPREME COURT** should provide by rule that expert and other testimony at involuntary commitment proceedings may be done by electronic means, including real-time video conferencing. To be consistent with due process, video conferencing should be used only where

short periods of custody are being considered.

13.3 If the **LEGISLATURE** changes and strictly limits the provisions as to who may file petitions in involuntary commitment proceedings, the **SUPREME COURT** should change its rules to permit facsimile or electronic filing.

13.4 The **SUPREME COURT** should ensure that appropriate privacy safeguards are put into place before implementing electronic filing.

APPENDICES

Appendix A:	Administrative Order
Appendix B:	Public Forum Summary By City
Appendix C:	Comments from the Public Forums and Written Submissions
Appendix D:	Survey Instruments
Appendix E:	Resource List
Appendix F:	Proposed Implementation Time Line

APPENDIX A

ADMINISTRATIVE ORDER

SUPREME COURT OF APPEALS OF WEST VIRGINIA

WHEREAS, the law of West Virginia has placed with the judicial branch of government, under the direction of the West Virginia Supreme Court of Appeals, a central role in the administration of the State's mental hygiene laws; and

WHEREAS, medical, scientific, social, and jurisprudential understanding, treatment, and response to mental illnesses, disorders and conditions have undergone a significant transformation and change since West Virginia's current mental hygiene laws were enacted; and

WHEREAS, there is widespread consensus among patients, families, advocates, medical and social service professionals and providers, law enforcement officials, judicial officers, and other concerned and affected persons, that West Virginia's current mental hygiene laws and related practices, policies and procedures should be fully reviewed, and where desirable, improved and updated, to assure that they conform with current medical, social, scientific, and jurisprudential understanding; and

WHEREAS, the Commission on the Future of the West Virginia Judiciary, in its final report dated December 1, 1998, after receiving public comment regarding the State's mental hygiene laws and related practices, policies, and procedures, found and recommended, *inter alia*, that a commission should be appointed to review the State's mental hygiene laws and related practices, policies, and procedures, and to develop and advance recommendations for needed change;

NOW, THEREFORE, IT IS ORDERED that the Chief Justice of the West Virginia Supreme Court of Appeals shall appoint a "Commission on Mental Hygiene Reform," and direct that the Commission:

- (1) Review current mental hygiene laws, policies, practices, and procedures;
- (2) Assess the extent to which such laws, policies, practices, and procedures are meeting the needs of West Virginia and her people, in light of current medical, social, scientific, and jurisprudential understanding;
- (3) Identify and report on (a) the strengths of current laws, policies, practices, and procedures upon which to build; and on (b) areas of desirable improvement and change;
- (4) Develop and propose specific recommended changes to existing laws, policies, practices, and procedures (a) that are feasible and achievable, and can command a broad consensus of support among the diverse interested and affected constituencies; and (b) that will ensure that West Virginia's mental hygiene laws, policies, practices, and procedures are and will continue to be consistent with current medical, scientific, social and jurisprudential understanding; and

IT IS FURTHER ORDERED that the Commission submit its deliberations to the Supreme Court of Appeals in the form of a final report by December 10, 1999.

ENTER: February 10, 1999

LARRY V. STARCHER

CHIEF JUSTICE

APPENDIX B: PUBLIC FORUM SUMMARY BY CITY

The **MARTINSBURG FORUM** was held on Tuesday, May 18, 1999. The moderators were Jefferson County Sheriff William Senseney; Henry W. “Bucky” Morrow, former Mental Hygiene Commissioner; and Dr. Fred Donovan, Director, East Ridge Health Systems. There were twenty-eight people in attendance and ten of those addressed the Commission with their concerns and comments. The speakers focused on the need to decriminalize the commitment process (make it less adversarial and more treatment oriented), and the need for community-based secure treatment facilities. Other issues addressed were the: sheriff transport of respondents, the limited number of hospital beds, lack of appropriate training for court and hospital personnel, the need to maintain 24/7 services and crisis units, and the lack of facilities for adolescents. Among those who spoke were Assistant Prosecutor Chris Quesenart, and Mental Hygiene Commissioners Bob Burkhardt and Tracy Williams.

Held on Wednesday, May 19, 1999, the **MORGANTOWN FORUM** was moderated by Monongalia County Prosecuting Attorney Marsha Ashdown and former Mental Hygiene Commissioner Jerry Stone. Of the forty-three people who attended the meeting, seventeen spoke, including Helen Matlick, Project Director for the West Virginia Mental Health Consumer Association; Mental Hygiene Commissioner Howard Higgins; Mark Music, Regional Manager at Valley Mental Health Center; Chris McClelland, President of the Morgantown branch of the National Alliance for the Mentally Ill (NAMI); and Mary Raymond, Chair of the Public Policy Committee for the Mental Health Association. Lack of funding and inadequate staffing in mental health treatment programs and hospitals, and the lack of consistency and quality among service providers, were the main concerns voiced by speakers at this forum. Speakers also commented on the need for decriminalization of the commitment process; overcrowding at the State’s psychiatric hospitals; the need for better training for court and hospital staff; the lack of substance abuse treatment programs; the need for community facilities, peer counseling, and treatment options for adolescents; complications with dual diagnosis commitment; and the desire for better hospital staff communication with patients and their parents.

The Commission on Mental Hygiene Reform held the **BECKLEY PUBLIC FORUM** on Monday, May 25, 1999. Attorney Kent Bryson of the West Virginia Advocates moderated the forum which was attended by thirty-three people. Among the ten speakers were Mental Hygiene Commissioner Harold Wolf; Elizabeth McCullough, State President of the National Alliance for the Mentally Ill (NAMI) and a member of the Commission on Mental Hygiene Reform; Psychologist Greg Bolland; and the Honorable Larry V. Starcher, Chief Justice of the Supreme Court of Appeals of West Virginia. Seven speakers strongly advocated moving toward a clinical model to decriminalize the commitment process, and five people said there was a need for round-the-clock services and crisis intervention teams. Other issues discussed included concern about the inconsistent effort of attorneys representing respondents, the need for better training for court and hospital staff, the need for a voluntary commitment procedure, and the need for adolescent facilities.

The **CHARLESTON PUBLIC FORUM** was held on Tuesday, May 26, 1999. Moderators were Dr. Dallas Bailey of the Governor’s Cabinet on Children and Families, and Attorney Jane Moran.

There were forty-seven people in attendance. Among the sixteen speakers were Kanawha County Mental Hygiene Commissioner J.H. Crewsdon; Laurie Roberts, Director of Operations at the West Virginia Mental Health Consumer Association; and Tom Rodd, Law Clerk for the West Virginia Supreme Court of Appeals. The most frequently heard complaint at the Charleston Forum was the criminal nature of the involuntary commitment process; nine people suggested moving toward a medical model. Four others said that round-the-clock service and crisis intervention were needed, and that the lack of a voluntary commitment procedure was a serious problem. Additional issues mentioned at the forum included: the lack of funding for services, inadequate facilities, the need for better hospital and court staff training, and the need to change the dangerousness standard so that persons who are not yet “dangerous” but spiraling downward toward that condition can be treated involuntarily.

APPENDIX C

Commission on Mental Hygiene Reform A Sampling of Comments (Paraphrased)

Received at the Commission on Mental Hygiene Reform Public Forums

A consumer advocate said: "I've talked to over a hundred people about the commitment law, and people would like to see an observation period, where maybe the problem can be solved before we commit to a state hospital. We also need peer assistance, crisis intervention, respite care, and advance directives."

A consumer said: "We need a better system, with people who can work with clients. People can't get medication."

A parent said: "We need court-appointed advocates for persons with mental illness."

A crisis worker said: "Advocates need more training."

A mental hygiene commissioner said: "We need to be attentive to the motivation in commitments. Hospitals are worried about liability in releasing someone, especially in close calls, and pass the buck to the mental hygiene commissioner."

A mental health center worker said: "Family members don't have the right to information they need. Forensics is placing a huge burden on the state hospitals."

A crisis worker said: "Temporary detention is helping us avoid commitments."

A consultant said: "We don't have proper placements and services for children with mental and emotional problems. We need prevention, not just reaction."

A consumer said: "Treatment in the community is much less expensive than hospitalization."

A parent said: "Why do we have to wait until someone's swinging a knife at his mother before somebody can intervene? We need to look at the 'dangerousness' standard."

A psychiatrist said: "We need much clearer rules about what we can do in emergencies. The forthwith hearing and the 10-day requirements are unworkable."

A mental health worker said: "Transportation needs to be looked at and simplified. Family members should not have to file petitions. The system needs to be revised."

A family member said: "This legal mess for someone who has a health problem is wrong. We need treatment help at home and instead we get commitment. This is awful."

A sheriff said: "People should not be caged up like animals in the back of one of our cars. We're not medical people. The short-term stays and revolving door admissions are a tremendous waste of our time."

A prosecutor said: "Our procedure is too formal and too adversarial by far. Petitions are not always emergencies. A hearing in 72 hours would be much better --most people are released by then."

A prosecutor said: "Our system doesn't work. We should have initial evaluations by two physicians or psychologists who could temporarily commit. We need to use voluntary hospitalizations."

Another prosecutor said: "We need a system with less lawyers and more medically-trained people."

A deputy said: "We drive 300 to 400 miles one way to take a person to the hospital for 2 days. It makes no sense. Attending hearings at all hours also makes no sense."

A county commissioner said: "We need a place locally to take care of people. The trip to Weston is too far and expensive. A hearing costs us hundreds of dollars."

A public defender said: "I represent these people and I've done dozens of hearings. We don't need lawyers making these decisions and we don't need these emergency hearings at all hours."

A doctor said: "It is unfair to put an intoxicated or psychotic person into a trial format. We can care for people in local hospitals with minimum funding. We need an outpatient commitment option, and a voluntary option."

A parent said: "We need to stabilize and maintain people in the community."

A mental hygiene commissioner said: "Advocates should be more like *guardian ad litem*s."

A parent said: "We need to decriminalize the process. We need post-hospitalization follow-up and after-care."

A consumer said: "The system is subject to abuse. I've been paraded in handcuffs like a criminal. We should get law enforcement out of the system."

A mental hygiene commissioner said: "We have 700 or 800 hearings a year. Returnees are a big problem, a revolving door. Juveniles pose special challenges."

A parent said: "This legal/criminal model was terrible for us. We're talking about sick people. They gave me the choice of taking my son home or a homeless shelter. I took him with no prescription."

A consumer and care giver said: "We need community-based care and respite care."

A mental hygiene commissioner wrote: "Many people want treatment but there are no beds for voluntary patients. " We need a system that includes the voluntary commitment option."

A mental hygiene commissioner wrote: "We have no facilities to deal with the many juveniles who are sent to us. Many are not mental illness problems, they are behavior and discipline problems."

A parent said that: "The legal forum is inappropriate for medical decisions. Commissioners can ignore the medical recommendations for further hospitalization."

A judge wrote: "We need more funding for local mental health facilities and a procedure based on a medical model."

Another judge wrote: "The procedure is way too formalistic and too expensive, especially for short-term commitments."

A circuit clerk said: "Applications should be made at a local mental health facility, not the clerk's office."

A probation officer said: "There must be more training for commissioners. Juveniles are being lost in the system and need facilities."

A magistrate said: "Magistrates are not a good substitute for an on-call mental hygiene commissioner. Commissioners are often not available."

A circuit clerk said: "Expert exams at \$300 -\$500 each, several times a year, are a waste."

APPENDIX D

COMMISSION ON MENTAL HYGIENE REFORM **COURT PERSONNEL SURVEY**

As part of its ongoing effort to identify the most significant issues facing our mental hygiene system and to develop recommendations for change, the Commission on Mental Hygiene Reform is asking all court personnel to complete this survey. Do not give your name, but please indicate your position (judge, probation officer, magistrate assistant, etc.) in the space provided.

Position Title: _____

As part of your job, do you have any responsibilities with respect to mental hygiene proceedings? (circle one) YES or NO

Please list and briefly describe the three issues you see as most important regarding West Virginia's mental hygiene laws, policies, practices and procedures.

1. _____

2. _____

3. _____

Please list and briefly describe any changes you would suggest to reform or improve West Virginia's mental hygiene laws, policies, practices or procedures.

1. _____

2. _____

PLEASE RETURN TO THE "CMHR" c/o the ADMINISTRATIVE OFFICE BY 6/11/99
State Capitol Complex, Building One, Room E-100, Charleston, WV 25305

APPENDIX D

COMMISSION ON MENTAL HYGIENE REFORM **STAKEHOLDER SURVEY**

As part of its ongoing effort to identify the most significant issues facing our mental hygiene system and to develop recommendations for change, the Commission on Mental Hygiene Reform is asking all court personnel to complete this survey. Do not give your name, but please indicate your position (judge, probation officer, magistrate assistant, etc.) in the space provided.

Position Title: _____

As part of your job, do you have any responsibilities with respect to mental hygiene proceedings? (circle one) YES or NO

Please list and briefly describe the three issues you see as most important regarding West Virginia's mental hygiene laws, policies, practices and procedures.

1. _____

2. _____

3. _____

Please list and briefly describe any changes you would suggest to reform or improve West Virginia's mental hygiene laws, policies, practices or procedures.

1. _____

2. _____

PLEASE RETURN TO THE "CMHR" c/o the ADMINISTRATIVE OFFICE BY 6/11/99
State Capitol Complex, Building One, Room E-100, Charleston, WV 25305

APPENDIX E: RESOURCE LIST

All of the resources listed below were made available to the Commission on Mental Hygiene Reform and are on file with the Administrative Office of Courts.

A SPAN Retrospective, American Association of Suicidology, December 1995.

A Plan for the Prevention Research for the National Institute of Mental Health, National Advisory Mental Health Council.

A Supplement to the National Center for State Courts' Guidelines for Involuntary Civil Commitment for Families and Family Self-Help Organizations.

ABCNEWS.COM *Stopping the Stigma: Reader's Stories of Mental Illness* (June 8, 1999).
<<http://www.abcnews.go.com/sections/living/dailynews/mentalbbs.html>>.

Aldige-Hiday, Virginia and Scheid-Cook, Teresa L. *The North Carolina Experience with Outpatient Commitment: A Critical Appraisal*, International Journal of Law and Psychiatry, 215-232 (1987).

Aldige-Hiday, Virginia and Scheid-Cook, Teresa L. *Outpatient Commitment for "Revolving Door" Patients: Compliance and Treatment*, 179 The Journal of Nervous and Mental Disease, (1991).

Aldige-Hiday, Virginia and Scheid-Cook, Teresa L. *A Follow-up of Chronic Patients Committed to Outpatient Treatment*, 40 Hospital and Community Psychiatry, (1989).

Aldige-Hiday, Virginia and Scheid-Cook, Teresa L. *An Assessment of Outpatient Commitment in North Carolina*, 1 Education & Self Management Psych. Pl., (1987).

Aldige-Hiday, Virginia. *The North Carolina Experience With outpatient Commitment: A Critical Appraisal*, 10 International Journal of Law and Psychiatry, 215.

American Psychiatric Association. *Guidelines for Legislation on the Psychiatric Hospitalization of Adults*; 1982.

Analysis of Oregon's Revised Statutes (OR. Rev. Stat.) OR Rev. Stat. 426.005- et seq. (1998).
<<http://www.psychlaws.org/legal%20resources/statelaws/oregon.html>>.

Analysis of Arizona Revised Statutes (Ariz. Rev. Stat.) M 36-518(A)-36-540(A)(1989).
<<http://www.psychlaws.org/legal.%20Resources/statelaws/analysisarizona.html>>.

Analysis, Annotated Code of the Public General Laws of Maryland, Published by Michie Company (Md. Code Ann.) 10-101 et seq. (1998). <<http://www.psychlaws.org/legal%20resources/statelaws/analysismaryland.html>>.

Analysis of West's Annotated California code Welfare and Institutions Code 5000 et seq. (1998).
<<http://www.psychlaws.org/legal%20resources/statelaws/analysiscalifornia.html>>.

Analysis of District of Columbia's Code, Ann. 21-500 et seq. (1997 Supp.).
<<http://www.psychlaws.org/Legal%20resources/statelaws/analysisdc.html>>
D.C. Code Ann 21-501- et seq. (1981); <http://www.psychlaws.org/legal/%20resources/statelaws/D.C.statute.html>.>
D.C. Code Ann 21-301-et seq. (1981); <<http://www.psychlaws.org/legal%20resources/statelaws.DCstatute.html>>

Analysis of West's Florida Annotated Statutes (Fla. Stat. Ann.) 394.462-394.467 (1998).
<<http://www.psychlaws.org/legal%20resources/statelaws/analysisflorida.html>>

Andreasen, Nancy. *Understanding the Causes of Schizophrenia*, 34 The New England Journal of Medicine, (1999).
<<http://www.nejm.org/content/1999/0340/0008/0645.asp>>.

Ariz. Rev. Stat. 36-501- et. Seq (1998). <<http://www.psychlaws.org/legal.%20resources/statelaws/arizonastatute.html>>.

Arizona Revised Statutes Annotated 1956, Chapter 129, Volume 11A, Title 36, "Public Health and Safety, Ariz. Rev. Stat. Ann 36-501-36-540.

Back to Bedlam: NBC and Geraldo Make Things Worse. <<http://www.madnation.org/geraldo.htm>>.

Beard, John H., Propst, Rudyard N., and Matamud, Thomas J. *The Fountain House Model of Psychiatric Rehabilitation*, 1 Psychosocial Rehabilitation Journal, (1982). *Fountain House Movement Summary* (assisted care).

Bellevue Outpatient Commitment Program (1995); Bellevue Hospital Center, First Avenue at 27th Street, New York, NY 10016.

Boust, Susan, M.D. *Assertive community treatment is working in Nebraska*. NAMI Advocate, April/May 1999 at 32.

Brasher, Philip. *Bill Would Revise Mental Health Law*, (APW), Yahoo! News, April 14, 1999.

Breaking the silence curriculum to be launched at NAMI convention. NAMI Advocate, April/May 1999 at 15.

Buchanan, Donnie. *Commitment to Recovery* (undated) (first-person account of Schizophrenia).

Bursten, Ben, M.D. *Posthospital Mandatory Outpatient Treatment*, 143 Am. J. Psychiatry, 1255-1258 (1986).

Butterfield, Fox. *Experts Say Study Confirms Prison's New Role as Mental Hospital.* New York Times, July 12, 1999.

Bylaws amendments, 1998 NAMI Election, NAMI Advocate, April/May 1999 at 27.

CARF Behavioral Health Standards for Assertive Community Treatment Programs, Field Review Draft, June 1999.

Center for Mental Health Services Meeting Objectives, December 10-11, 1997. <<http://www.mentalhealth.org>>. Concerns and questions about involuntary interventions and coercion; effective practices for reducing coercion and involuntary interventions and methods of disseminating effective practices; recommendations for CMHS regarding knowledge dissemination and research.

Claire, Morgan. *A Legal Guardian Angel, A Story of the Struggles and Success of a Bi-polar and His Wife*, undated.

Clancy, Gerard, M.D. and Williams, Nancy. *Better Late Than Never*, slide presentation, PACT in Iowa.

Cloud, John. *Mental Health Reform, What It Would Really Take.* Time, (June 7, 1999).

Coalition to Stop Outpatient Commitment Advocacy Materials: New York. <<http://www.madnation.org/tools/NYCoalition.htm>>.

Comprehensive Community Behavioral Health Programs, West Virginia.

Consequences of Non-Treatment, TAC. <<http://www.psychlaws.org>>.

Consumer Organization & Networking Technical Assistance Center, *Coalition to Stop Outpatient Commitment.* <<http://www.contac.org/coalition.htm>>.

Court Sets Limits On Disabilities Act, All Things Considered, National Public Radio, June 23, 1999. <<http://www.npr.org/news/national>>.

CTAC, *California Treatment Advocacy Coalition Recommendations.* <<http://www.contac.org/cac.htm>>.

Dale, Mary Clair. *Man Who Died In Jail Was Ill .* Charleston Gazette, April 12, 1999 (mentally ill man who died in Police custody).

Dale, Mary Clair. *Suspect Who Died Was Mishandled.* Charleston Gazette, April 12, 1999 (police mishandling leads to death of mentally ill man).

Dendrite Alert, February 15, 1999. <<http://www.madnation.org/tools/ORalert.htm>>

Developing A Strategic Plan, National Institute of Mental Health, June 1999.

District of Columbia Code, 1981

- a. DC-ST-ANN- DC ST s 21-545
- b. DC-ST-ANN- DC ST s 21-521
- c. DC-ST-ANN- DC ST s 6-2032
- d. DC-ST-ANN- DC ST s 21-542
- e. DC-ST-ANN- DC ST s 21-503
- f. DC-ST-ANN- DC ST Mental Health Rule 11- General provisions
- g. DC-ST-ANN- DC ST s 21-546

Dixon, Lisa B. M.D., M.P.H., DeVeau, Jane M., M.D. *Dual Diagnosis: the double challenge.* NAMI Advocate, April/May at 16.

Dobbin, Ben. *Ending Mental Illness Isolation Patients Problems Ease With Help From Friends, Family.* The Associated Press (June 6, 1999). <<http://www.abcnews.go.com/sections/living/dailynews/mentalillness99060.html>>.

Don't force mentally ill to take drugs. Health- BBC Online, September 18, 1998. <<http://www.expatient.org/dontforcementallyill.htm>>.

Emerging Choices in Anti-Psychotic Medications. 27th Annual Meeting of the ASCP, Nov. 13-16, 1996.

Employment Intervention Demonstration Program (pamphlet).

Fact Sheet: New treatment options for bipolar disorder. NAMI Advocate, April/May 1999 at 30.

Faulkner Yates, Kathy. *Therapeutic Issues Associated With Confidentiality and Informed Client Consent in Forensic Evaluation.* 20 Criminal and Civil Confinement, 345 (1994).

Fisher, Daniel. *Alternative to PACT: Recovery at Your PACE.* <<http://www.contac.org/pace.htm>>.

Florida Stat. Ann 394.463. *et seq.* <<http://www.psychlaws.org/legal%20resources/statelaws.floridastatute.html>>.

Friedrich, Rose Marie, Armstrong, Moe, and Flory, Curtis. *A Consumer Perspective On Long Term Care.*

From Isolation to Opportunity: The Clubhouse, International Center for Clubhouse Development.
BRIDGES (pamphlet sponsored by Tennessee Mental Health Consumers Association, Tennessee Alliance for the Mentally Ill, Tennessee Department of Mental Health and Mental Retardation).

Galvin, Kevin. *Demystifying Mental Illness, White House Conference Meant to Dispel Myths.* ABCNEWSliving.com (June 7, 1999). <<http://www.abcnews.go.com/sections/living/dailynews/mentalillness990607.html>>.

Geller, Jeffrey L., M.D., M.P.H. *On Being "Committed" to Treatment in the Community*, 1 Innovation and Research (outpatient commitment), (1993).

Geller, Jeffrey L., M.D., M.P.H. *Clinical Guidelines for the Use of Involuntary Outpatient Treatment*, 41 Hospital and Community Psychiatry, (1990).
(ten consequential guidelines).

General Statutes of North Carolina Chapter 122C, Mental Health, Developmental Disabilities and Substance Abuse Act of 1985, N. C. Gen Stat. 122C-1- *et seq.* <<http://www.psychlaws.org/legal%20resources/statelaws/Northcarolina statute.html>>.

Geyso, Helen M. and Beilman, Robert L. Beilman, M.D., Eds. *Mental Health Services for Mentally Ill Persons in Jail.* NAMI Wisconsin.

Gleason Rappaport, Mary. *Going public with the very personal experience of mental illness.* NAMI Advocate, April/May 1999 at 4.

Governor Cecil H. Underwood, Community Action Grants for Service Systems Change, State of West Virginia.

Greenhouse, Linda. *High Court Limits Who Is Protected By Disability Law.* New York Times, June 23, 1999.
<<http://www.nytimes.com/library/politics/scotus/articles/062399disable-discrim.html>>

Guideline for Treatment of Adults. American Psychiatric Association. <<http://www.psych.org>>.

Guidelines for Involuntary Civil Commitment Part B, Screening: Organization and Administration. Mental and Physical Disability Law Reporter; September-October 1986.

Hardin, Herschel. *Uncivil Liberties.* Vancouver Sun, July 22, 1993.

Hawaii Revised Statutes 1996 Supplement, HAW.REV.STAT., General and Administrative provisions, 334-1.

Hawaii Statutes.

Health Care Plan Design and Cost Trends -- 1988 through 1997, Prepared for: National Association of Psychiatric Health Systems, Association of Behavioral Group Practices and National Alliance for the Mentally Ill, May 1998.

Honberg, Ron. *Supreme Court Rules in favor of services for student with disability.* NAMI Advocate, April/May 1999 at 9.

House Bill 4604, February 1998. *A Bill to Amend and reenact W. Va. Code 27-5-1.*

House Bill 3780. *Medicare payment system for psychiatric facilities.*

Inpatient/Outpatient Commitment Standards. Alabama, Georgia, Hawaii, North Carolina, New York.

Involuntary Commitment at Heart of Division Within NAMI Ranks, (Mental Health Weekly, 08/24/98, Vol. 8 Issue 33, p1, 3p.). <<http://www.expatient.org/involuntarycommitment.htm>>.

Involuntary Commitment to Outpatient Treatment, Report of the Task Force on Involuntary Outpatient Commitment (1987)
Involuntary Outpatient Treatment; Studies of Outpatient Commitment; Studies of Outpatient Commitment; The Impact of Recent Statutory Changes; Implications for the Future use of Outpatient Commitment; Proposed Supplement to American Psychiatric Association's Guidelines for Legislation on the Hospitalization of Adults; References.

Iowa Code 229.1- *et seq.* <<http://www.psychlaws.org/legal%20resources/statelaws/iowastatute.html>>.

Issac, Rael Jean and Brakel, Samuel Jan. *Subverting Good Intentions: A Brief History of Mental Health Law Reform*, 89 Cornell Journal of Law and Public Policy, (1992).

Issac, Rael Jean and Jaffe, D.J. *Toward Rational Commitment Laws - Committed to Help*, National Review, January 29, 1996 at 34, 36, 38.

Jacobs, Carla, Galton, Elizabeth, and Howard, Beth. *A New Vision for Mental Health Treatment Laws- A Report by the LPS Reform Task Force.*

Jacobs, Carla and Torrey, E. Fuller, M.D. *California Must Strengthen LPS Act for Mentally Ill*, February 16, 1999.

- Jacobs, Carla. *California Must Care For Not Criminalize the Severely Mentally Ill*, February 16, 1999, Statement- California TAC.
- Jaffe and Griffin. *Involuntary Commitment, Pro and Con*.
- Jaffe D.J. *How and Why to Change Involuntary Treatment Policies In Your State*. <<http://www.schizophrenia.com>>.
- Jaffe D.J. *Putting Assisted Treatment Laws in Legal Context*.
- Jordan, Bettina. An analysis of *Hawks v. Lazaro*, 1974, (Dec. 7 1998).
- Kaplan, Robert. *National Study of Outpatient Commitment Laws*, March 3, 1994.
- Key Findings*. The Hay Group Study on Health Care Plan Design and Cost Trends, 1997-1998.
- Kress, Kenneth J. *Suggested Outpatient Treatment Statute*, University of Iowa College of Law, (May 5, 1999).
- Kress, Kenneth J. *Judicial Advocates Annual Meeting, Involuntary Commitment in Iowa*, (April 15, 1999).
- Kress, Kenneth J. *Letter from Prof. Kenneth J. Kress Regarding New York Outpatient Commitment Bill*, March 16, 1998.
- Kress, Kenneth J. *An Outline of Iowa Civil Commitment Law*.
- Kress, Kenneth J. *Should Iowa Adopt an Outpatient Treatment Statute?* NAMI- Johnson Co., (April 21, 1999).
- Landers, Ann. *Laws Must Help Mentally Ill*.
- Leasure, Bartemes, Brodie, Patnaik, *The Mental Hygiene Process in West Virginia: A Survey*, (May 31, 1996), unpublished manuscript on file with the West Virginia Advocates.
- Leibovich, Lori. *Interview with Dr. E. Fuller Torrey*, The Schizophrenia Homepage, (January 1997). <<http://www.schizophrenia.com/family/torreyintv.html>>
- Letter from Richard L. Coffinbarger, Crisis Services Specialist, to William F. Byrne, Chair, Commission on Mental Hygiene Reform* (June 2, 1999).
- Letter to Judge Larry Starcher, WV Supreme Court of Appeals, from H. Richard McCullough*, (May 21, 1999).
- Letter to "State Medicaid Director" from Health Care Financing Administration (HCFA), June 7, 1999.
- Locations of Plans for Achieving Self Support (PASS) Cadres, Social Security Administration.
- Lundin, Robert. *On Poverty and Mental Illness*, NAMI Advocate, April/May 1999 at 13.
- Manhard, Bob. *Are Those With NBD Really Free to Choose?*
- Mann, Susan. *Life of Normalcy or Life of Chaos*, undated, (lawyer's narration of battle with schizophrenia).
- Marshall, Christopher C. *Social Security Administration increase in allowable earnings takes effect July 1, 1999*, NAMI Advocate, April/May 1999 at 7.
- Maryland Code Ann. 410-101-et seq.
- McCrery-Cardin Medicare Facility Payment Reform Legislation*, Act of 1998.
- McKinley's Consolidated Laws of New York*, Annotated Mental Hygiene Law, NY Ment Hyg s 9.61
- Memphis Police Crisis Intervention Team Booklet
- a) Mission Statement.
 - b) Ana a. Lima, *Police Can Adapt, panel members told*, The Press-Enterprise, April 1, 1999.
 - c) Donald G. Turnbaugh, *Curing Police Problems with the Mentally Ill*, The Police Chief, February 1999.
 - d) Shankar Vedantam, *Phila. police hear about program for dealing with the mentally ill*, The Philadelphia Inquirer, Friday, February 26, 1999.
 - e) Kathleen Sweeny, *No crisis here*, The Florida Times -Union, January 19, 1999.
 - f) Chris Conley, *Police with training reach mentally ill first*, The Commercial Appeal, January 6, 1999.
 - g) John G. Carlton, *Police Patient in Memphis*, St. Louis Post-Dispatch, April 27, 1997.
 - h) Jeff Jones, *Alternative to Force*, Albuquerque Journal, January 28, 1997.
 - i) letter to Director Walter Winfrey, Memphis Police Department, from Randy Borum, Ph.D., September 18, 1996.
 - j) Toni Lepeska, *Crisis classes for cops expand*, The Commercial Appeal, November 7, 1995.
 - k) Quintin Robinson, *Crisis team has reduced police harm to patients*, The Commercial Appeal, June 4, 1992.
 - l) Beverly Stuart, *Policemen gather to study working with mentally ill*, The Commercial Appeal, November 3, 1991.
 - m) Ron Maxey, *Squad answers call to crisis relief*, The Commercial Appeal, March 7, 1991.
 - n) Joy Powell, *Police face challenge to deal with mentally ill*, Courier, November 27, 1990.

- o) Kimberly K. Ford, *Coping With Crisis of the Streets on Memphis*.
- p) Captain Walter Crews and Lt. Sam Cochran, *Crisis Intervention Team*, Memphis Police Department.

Mental Health- Senate Bill No. 564, February 18, 1991, Committee on Health and Human Resources and the Committee On The Judiciary.

Michelson, Gail. *Comparison of Selected States Mental Hygiene Statutes*

- a. Selected Statutes regarding Definition of Mental Illness.
- b. Selected Statutes regarding Dangerousness Standards.
- c. Selected Statutes regarding Involuntary Commitment Standards.
- d. Selected Statutes regarding Emergency Detention.
- e. Selected Statutes regarding Tribunals.
- f. Selected Statutes regarding Outpatient Commitment Standards.
- g. Selected Statutes regarding Oversight.
- h. Selected Statutes regarding Advance Directives.

Miller, Dawn. *Services for Mentally Retarded Will Be Topic of Public Hearing*, WV Gazette, February, 22, 1999. <<http://www.wvgazette.com/news/services0222.html>>.

Miller, Dawn. *Decree On Care For Retarded No Longer Needed, State Says*, Charleston Gazette, April 19, 1999.

Minnesota Statutes, Minn.Stat. 253.015 -et seq. <<http://www.psychlaws.org/legal%20resources/statelaws/minnesotastatute.html>>.

Morrow, Henry W., Jr. *A Profile of Mental Hygiene Courts in the State of West Virginia*, April-July 1995.

Morrow, Henry W., Jr. *Mental Hygiene Issues -- 1996 Judge's Conference at Pipestem*.

Munetz, Mark R., M.D. *The Effectiveness of Outpatient Civil Commitment*, 47 Psychiatric Service, 1251 (1996).

Mussomeli, Vito. *Preliminary Survey Regarding Mental Hygiene Hearings in West Virginia*.

Mussomeli, Vito. *The Flower-Child Statutes*, 10 The West Virginia Lawyer, (November 1996).

NAMI Policy Statement -- Involuntary Commitment and Court-Ordered Treatment, Oct. 7, 1995. <<http://www.NAMI.org>>

NAMI Empowers Consumers, Families to Take Control of Care By Putting First-of-Its-kind Treatment Guide Directly Into Their Hands, NAMI Press Room- March 24, 1998.

NAMI calls for stories on treatment-denied deaths, NAMI Advocate, April/May 1999 at 28.

NAMI Consumer and Family Guide to Schizophrenia Treatment, Treatment Works.

NAMI, Families On the Brink, The Impact of Ignoring Children With Serious Mental Illness, Results of a National Survey of Parents and Other Caregivers, June 1999.

NAMI, *PACT Across America: An Advocacy Strategy*. <<http://www.nami.org/about/pactacross.html>>.

NAMI/NYC, *Outpatient Commitment: The Evidence*. <<http://www.schizophrenia.com/ami/advacy/outpatient.html>>.

NAMI/ Program for Assertive Community Treatment Status Report, *Falling Through the Cracks: The Nation's Continued Failure to Provide Effective Care and Treatment for Individuals with the Most Severe Mental Illnesses*. <<http://www.nami.org/about/pactstatus.htm>>.

NAMI's Omnibus Mental Illness Recovery Act, Narrative Summary, "the bill is designed for the introduction in state legislatures."
NAMI- *A Blueprint for Mental Illness Recovery*, *NAMI Omnibus State Legislation Initiative*.

National Alliance for the Mentally Ill, *State-by-State availability of PACT Model Programs* (10/2/98). <<http://www.nami.org/about.chart.html>>.

National Probate Court Standards - Guardianship.

National Research and Training Center on Psychiatric Disability, pamphlet by the University of Illinois at Chicago.

Nebraska Statutes, Neb. Dev. Stat. 83-1001- et seq. <<http://www.psychlaws.org/legal%20resources/statelaws/nebraska.html>>.

New Directions in Research On Involuntary Outpatient Commitment, *Psychiatric Service*, (1995). (Letter from Marvin Swartz, M.D., Associate Professor, Duke University, October 14, 1998; Overview of Study procedures; Statistics- Outpatient Commitment Study.)

New Jersey Statutes, N.J. Stat Ann. 30:4-27.1 et seq. <<http://www.psychlaws.org/legal%20resources/statelaws/newjersey.html>>.

New York Treatment Advocacy Coalition, *Summary of The New York Attorney General's Outpatient Treatment Bill*.

New York "Kendra's Law." Legislative Bill Drafting Commission, 08318-02-9, at the request of the Attorney General 2/11/99.

New York TAC. <<http://www.psychlaws.org/NEWYORK/New%20York.htm>>.

Newsletter- National Depressive and Manic Depressive Association, Summer 1999.

North Carolina General Statutes Sec. 122C-272.

Official Code of Georgia Annotated, Volume 28, 1995 Edition, GA.Code Ann. 37-3-1--37-3-95.

Office Employment Support Programs, Social Security Administration.

Office of Behavioral Health Services and the Supreme Court of Appeals Training Manual, *Best Practices for Involuntary Commitment*, (Summer 1998) (contains the following sections a-k: a. Mental Hygiene Legal Procedure; b. Selected Provisions of West Virginia State Code, Chapter 27; c. The Code of Judicial Conduct; d. Case law abstracts; e. Supreme Court of Appeals Inventory of Forms for Mental Hygiene Proceedings; f. Code of Judicial Conduct (in a nutshell);, g. Best practices for Individuals with Mental retardation/ Developmental Disabilities; h. Best Practices for Adults with Mental Illness; i. Best Practices for Substance Abuse Treatment; j. Conservators and Guardians in the State of West Virginia; k. Scoring and Interpreting BPRS-C in Involuntary Commitment evaluations.

Olmstead v. L.C., 1999 WL 407380 (U.S.).

Omnibus Mental Illness Recovery Act, NAMI.

OR Rev. Stat. 426.005- *et seq.* <<http://www.psychlaws.org/legal%20resources/statelaws/oregon.html>>.

Osburn, Lisa D. *How Our Laws Failed to Protect the Unprotected*, Huntington Herald Dispatch, Sunday, February 7, 1999. Problems with sheriff's departments acting as conservators for mentally ill.

Outpatient Commitment Reduces Hospital Stays, Violence and Improves Odds of Recovery For People With Severe Mental Illnesses, TAC. *Consequences of Non Treatment*.

Panel Symposium Presented at the Annual NAMI Conference, *A Multisite Study of Mental Health Services & Rehabilitation Research on Unemployment*, Center for mental Health Services, July 1999, Chicago.

Parry, John. *Involuntary Civil Commitment in the 90's: A Constitutional Perspective*, 18 Mental and Physical Disability Law Reporter, 320 (1994).

Patients With Schizophrenia Occupy One in Twelve Hospital Beds, September 19, 1999. <<http://www.pslgroup.com>>.

Perlin, Michael L. *Therapeutic Jurisprudence: Understanding the Sanist and Pretextual Bases of Mutual Disability Law*, 20 Criminal and Civil Confinement, 369 (1994).

Potter, Ned. *The State of Mind, Mental Illness Becomes Part of the National Agenda*, ABCNEWS₂.com, (June 7, 1999). <http://www.abcnews.go.com/onair/closerlook/wnt990607_mental.html>.

Pre- Admission Screening Form.

Progress report for The Nations First Mental Health Court, 17th Judicial Circuit, Florida, July 1997- June 1998.

Project ABLE (Able Beneficiaries' Link to Employers), Social Security Administration, December 1997.

Recommendations for the King County Mental Health Court, August 1998.

Report: Problems and Recommendations; Chief Justice's Advisory Committee on Mental Health Issues in West Virginia, December 1990 and Jan 8, 1991.

Research, NAMI Advocate, April/May 1999, at 18.

Rohland. Barbara M., M.S., M.D. *The Role of Outpatient Commitment in the Management of Persons with Schizophrenia*, Iowa Consortium for Mental Health, June 1998.

Ross, E. Clarke, D.P.A. *Why advocating for an unduplicated count of persons served the public mental health system is essential for health-system accountability*, NAMI Advocate, April/May 1999 at 11.

Ross, E. Clarke, D.P.A. *Now is the time to contact Congress to reduce the restraint-related deaths and injuries*, NAMI Advocate, April/May 1999 at 6.

Ross, E. Clarke, D.P.A. *Reluctance to serve persons with co-occurring disorders is obstacle to SAMHSA's future*, NAMI Advocate, April/May 1999 at 7.

Ross, E. Clarke, D.P.A. *Mutual reinforcement: NAMI's omnibus recovery state initiative and federal policy agenda*, NAMI Advocate, April/May 1999.

Schizophrenia Research, National Institute of Mental Health, March 1999.

Schizophrenia: Youth's greatest Disabler, The British Columbia Schizophrenia Society, March 1997. <<http://www.mentalhealth.com>>.

Senate Bill No. 770, March 4, 1998.

Senate Concurrent Resolution No. 38, with cover letter from Joan Ohl to Earl Ray Tomblin and Robert S. Kiss dated May 23, 1997.

Senators Domenici, Wellstone introduce severe mental illness parity legislation, NAMI Advocate, April/May 1999 at 1.

Shannon, Jackie, NAMI Board President. *Recovery from severe mental illness- a reality within our grasp*, NAMI Advocate, April/May 1999 at 12.

Sharkey, Joe. *Mental Illness Hits The Money Trail*, The New York Times, June 6, 1999.

SPAN- *Suicide Prevention Advocacy Network*, Newsletter, June 1999.

Sperling, Andrew, Bohlman, Robert, and Dore, Susan. *Parity Update*, NAMI Advocate, April/May 1999 at 8.

Spotlight on 1999 NAMI Campaign Awards, NAMI Anti-Stigma Foundation.

Stanley, Jonathan, Esq. *New York Must Strengthen Assisted Treatment Laws for Mentally Ill*, January 25, 1999. Attorney General Eliot Spitzer, *Spitzer Unveils Plan to Ensure That Mentally Ill Take Prescribed Medication, Involuntary Outpatient Treatment Act*, January 28, 1999.

Stanley, Jonathan. *Wyoming's Great Leap*. <<http://www.psychlaws.org/newyork/wyominglaw.html>>.

Starcher, Larry V. *Mental Hygiene Reform*, The West Virginia Lawyer, April 1998 at 8.

State Partnership Initiative, Social Security Administration.

States consider legislation favoring coverage for off-formulary drugs, NAMI Advocate, April/May 1999 at 31.

Stavis, Paul and Patraghini, Amy. *Violent Acts by Persons with Mental Illness: What Are Societies Options Under the Current Law?*

Stavis, Paul. *New York State Commission on the Quality Care For the Mentally Ill*.

Stavis, Paul. *A Very Old Idea Whose Time Has Returned* (conditional discharge).

Stavis, Paul. *Involuntary Hospitalization in The Modern Era: Is "dangerousness" Ambiguous or Obsolete?*, (Subtle changes in the meaning of one legal term "dangerousness" and the impact it has had to further limit the use of civil commitment).

Stavis, Paul. *Psychiatric Involuntary Treatment: Developments in Mental Hygiene Law in 1993, Involuntary Commitment and Treatment*.

Stavis, Paul. *Civil Commitment Past, Present and Future*, July 21, 1995, Washington D.C.

Sundram, Clarence J. and Stavis, Paul F. *New York's Surrogate Decision Making Law -- Ten Years later*, New England Journal of Medicine, 1368 (1988).

TAC, *State Statutes Incorporating a "Need For Treatment" Standard*.

TAC Newsletter, April 4, 1999 (*Alarming jail Survey results*).

TAC Newsletter- May 7, 1999, *Key Legal Decisions Affecting Treatment* (cont.), 3 of 3.

TAC Statement, May 19, 1999 *Assisted outpatient treatment will help reduce preventable episodes of violence, homelessness, and incarceration in New York*.

TAC Newsletter, April 3, 1999 (*WV Supreme Court of Appeals Commission on Mental Hygiene Reform*).

TAC Newsletter, undated, *Homelessness, Incarceration, Episodes of Violence: Way of Life for Almost Half of Americans with Untreated Mental Illness*, (analysis of violence and crime committed by several mentally ill. Placement of mentally ill in prison).

TAC, *Examples of Different Procedural Models Used In Other States -- Nebraska, New Jersey, New York*.

TAC Newsletter- May 28 1999, *Canada's Experience with Assisted Outpatient Treatment*:

- a. Herschel Hardin, *Extended Leave/ Community Treatment Orders*;
- b. Jonathan Stanley, *Wyoming's Great Leap*;
- c. E. Fuller Torrey and Mary Zdanowicz, *Treatment Advocacy Center Op-Ed in LA Times*.

TAC Newsletter- May 7, 1999, *Commitment to Recovery*, 2 of 3.

TAC, *Outpatient Commitment Reduces Hospital Stays, Violence and Improves Odds of Recovery for People with Severe Mental Illness*. <<http://www.psychlaws.org.html>>.

TAC, Medical and Legal Resources -- Summaries of articles published in professional journals, **a.** Insight, **b.** Consequences of Non-treatment, **c.** Victimization. Homepage guiding readers to articles on key issues impacting the legal rights of individuals with severe mental illness, State laws with analysis of assisted treatment laws. <<http://www.psychlaws.org>>.

TAC- *Criminalization of Americans with Severe Psychiatric Illness*.

TAC- *Manic Depressive Illness Facts*.

TAC- *Essay on Lanterman-Petris Law and scientific advances since its passage in 1967*, released March 17, 1999.

TAC- *Changing Laws to Ensure Treatment*. <<http://www.psychlaws.org.html>>.

TAC- *Schizophrenia Facts*.

The Associated Free Press, Homelike Settings for Mentally Ill. N.Y. Times, June 22, 1999. <<http://www.nytimes.com/aponline/w/AP-court-Mentally-disabled.html>>

The Minnesota Law. <<http://www.madnation.org/MNlaw.htm>>.

The MacArthur Coercion Study, September 1998. <<http://www.expatient.org/themacarthurcoercion.htm>>

The NAPHS Benchmarking Initiative, 1998 Committee.

The Effectiveness of Outpatient Civil Commitment, 47 Psychiatric Services, (1996).

The Rehabilitation Accreditation Commission, Behavioral Health.

The Carf Story, pamphlet, NAMI.

Title 64, Legislative Rule, Department of Health and Human Resources, 64CSR59, Behavioral Health Client Rights.

Title 64, Legislative Rule, DHHR Series 59, (Behavioral Health Client Rights).

Torrey, E. Fuller and Mary Zdanowicz. *Why Deinstitutionalization Turned Deadly*, The Wall Street Journal, August 4, 1998.

Torrey, E. Fuller and Mary Zdanowicz. A Right To Mental Illness?, New York Post, May 28, 1999. <<http://www.psychlaws.org/general%20resources/article14.html>>.

Torrey, E. Fuller. *Schizophrenia and Manic Depressive Disorder Are Diseases of the Brain*.

Torrey, E. Fuller and Mary Zdanowicz. *We Need To Ask Again: Why Do Severely Mentally Ill Go Untreated?*, The Boston Globe, August 1, 1998.

Torrey, E. Fuller and Mary Zdanowicz. *How Freedom Punishes the Severely Mentally Ill*, USA Today, June 7, 1999.

Torrey, E. Fuller. *How Freedom Punishes the Severely Mentally Ill*, USA Today, June 7, 1999.

Torrey, E. Fuller, M.D., and Kaplan, Robert Kaplan. *A National Survey of the Use of Outpatient Commitment*, 46 Psychiatric Services, (1995).

Treatment Advocacy Center (TAC) Newsletter, March 19, 1999 (*Connection between Medically Untreated Severe Mental Illness and Violence*).

Understanding Schizophrenia, February 19, 1999, Dateline NBC. <<http://www.msnbc.com/news/242561.asp>>. (Margaret Wray's Family Speaks Out/ Dr. Xaxier Amador).

Van Putten, Robert A., Santiago, Jose M., M.D., and Barren, Michael R., Ph.D. *Involuntary Outpatient Commitment In Arizona: A Retrospective Study*, 39 Hospital and Community Psychiatry, 953 (1988).

Welcome to the Treatment Advocacy Center, March 3, 1999, (re: policy of Treatment Advocacy Center; pro and con discussion of right to treatment from TAC perspective).

West Virginia Office of Behavioral Health Services Division on Alcoholism and Drug Abuse, Technical Review Report: System Readiness for Managed Care, June 1, 1999.

West Virginia Supreme Court Commission on the Future of the Judiciary, Issue 16: Appropriateness of the Adversarial Model In Mental Hygiene Proceedings (1998).

What people are saying about NAMI actions. <<http://www.madnation.org/news/oppressors/peoplesay.html>>.

Winerp, Michael. *Bedlam on the Streets*, The New York Times, May 23, 1999.

Wisconsin Statutes, Wis. Stat. 51.001 et seq. <<http://www.psychlaws.org/legal%20resources/statelaws/wisconsin.html>>.

Your Money Goes Far at These A+ Charities, Money, (1998). <<http://money.com.html>>.

Zanni, Guido, Ph. D. *Inpatient Stays Before and After Outpatient Commitments*, 37 Hospital and Community Psychiatry, at 941 (1986).

- a. *Involuntary Commitment*, News Stories;
- b. Issac, Jaffe. *Health Care Proxies and A Potentially Easier Way To Get Someone Help Before They Become A Danger To Self or Others*;
- c. Manhard. "Mini-Manual" *Reasons Why Involuntary Admittance and Treatment Is Needed and Justified*, The Schizophrenia Homepage. <<http://www.schizophrenia.com>>;
- d. *Involuntary Treatment: A Family Perspective*, The Schizophrenia Homepage. <<http://www.schizophrenia.com>>;
- e. *Outpatient Commitment Info*, 1995, The Schizophrenia Homepage. <<http://www.schizophrenia.com>>;
- f. *Peoples' Experiences With Involuntary Treatment*, The Schizophrenia Homepage. <<http://www.schizophrenia.com>>.

<<http://www.misanity.org.html>>.

66 Police Chief magazine; 52-54 (1999).

APPENDIX F: PROPOSED IMPLEMENTATION TIME LINE

Issue Number	Rec.	Responsible Party	Immediately	Within 2 Years	Beyond 2 Years
1	1.1-1.7	Legislature	----->	FULL	
2	2.1	Legislature	----->	FULL	
	2.2	County Commissions (CC)	NOW		
	2.3\$\$\$	Legislature/CC	----->	FULL	
3	3.1	Legislature	NOW		
	3.2	Legislature	NOW		
	3.3	Legislature	NOW		
4	4.1	Legislature	----->	FULL	
	4.2	DHHR	----->	FULL	
	4.3	Legislature	----->	FULL	
5	5.1	Reformed System	ONGOING	ONGOING	ONGOING
	5.2	Legislature	ONGOING	ONGOING	ONGOING
	5.3	Legislature	----->	FULL	
	5.4\$\$\$	Legislature	1/3	1/3	FULL
	5.5\$\$\$	Legislature	NOW		
	5.6	CMHC ¹⁷	NOW		
6	6.1	Legislature	ONGOING	ONGOING	ONGOING
	6.2\$\$\$	DHHR	-----PARTIAL----->		FULL
	6.3	Legislature	----->	FULL	
	6.4	Treatment Providers	----->	FULL	
	6.5 \$\$\$	DHHR, DOC, RJA	----->	FULL	
Issue Number	Rec.	Responsible Party	Immediately	Within 2 Years	Beyond 2 Years

¹⁷Community Mental Health Centers

7	7.1\$\$\$	Legislature	----->FULL		
	7.2	Statewide Commission	NOW		
8	8.1	Legislature	----->	FULL	
	8.2\$\$\$	Legislature	----->	FULL	
	8.3	DHHR	----->action follows legislation		
	8.4\$\$\$	Legislature/DHHR	----->FULL		
	8.5	WV's Schools	NOW		
	8.6	DHHR	NOW		
	8.7\$\$\$	DHHR/DJS	NOW		
9	9.1	DHHR/WVSCA ¹⁸	NOW		
	9.2\$\$\$	DHHR/OBHS ¹⁹	1/3	1/3	FULL
	9.3	DHHR/OBHS	NOW		
	9.4	WVSCA	----->	FULL	
	9.5	WVSCA	----->	FULL	
	9.6	WVSCA	----->	FULL	
	9.7	WVSCA	----->	FULL	
	9.8	OBHS/CMHC	----->	FULL	
	9.9	WVSCA	----->	FULL	
10	10.1	Legislature ²⁰	----->	FULL	
	10.2	Legislature	----->	----->	FULL
	10.3	Legislature	----->	FULL	
	10.4	All system participants	NOW		
Issue Number	Rec.	Responsible Party	Immediately	Within 2 Years	Beyond 2 Years

¹⁸West Virginia Supreme Court of Appeals

¹⁹Office of Behavioral Health Services

²⁰In conjunction with the implementation of Issue One's recommendations

11	11.1	DHHR/OBHS	----->	FULL	
	11.2\$\$	DHHR/OBHS	----->	FULL	
	11.3	DHHR/OBHS	NOW		
	11.4\$\$	DHHR/OBHS	----->	FULL	
	11.5	OBHS/CMHC	NOW		
12	12.1	WVSCA/OBHS	NOW		
	12.2	WVSCA/OBHS/CMHC	----->	FULL	ONGOING
	12.3\$\$	WVSCA/DHHR	----->	FULL	ONGOING
	12.4\$\$	WVSCA/WVCLE	----->	FULL	ONGOING
	12.5	Appointed Attorneys	----->FOLLOWS 12.4		
13	13.1\$\$	CMHC Psychiatric Hospitals	NOW		
	13.2	WVSCA	----->	FULL	
	13.3	Legislature/WVSCA	----->	FULL	
	13.4	WVSCA	----->	FULL	

\$\$\$-Indicates need for a fiscal note

*Supreme Court of Appeals of West Virginia
 Administrative Office of Courts
 State Capitol Complex
 Building 1, Room E-100
 Kanawha Boulevard, East
 Charleston, West Virginia 25305
 (304) 558-0145*

\